



COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES VERMONT PUBLIC MEETING TRANSCRIPT

Burlington, Vermont
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DAY 1—OCTOBER 23, 2014

Presenters:

- Tammy Simoneau, Parent
- Cindy Walcott, Deputy Commissioner, Family Services Division, Vermont Department for Children and Families (DCF)
- Terry Cross, Director, National Indian Child Welfare Association
- Dr. Emily Douglas, Associate Professor, School of Social Work, Bridgewater State University
- Theresa Costello, Executive Director, ACTION for Child Protection
- Kyle Hoover, Investigation/Assessment Social Worker
- Shawn Vetere, Social Worker
- Matthew Bergeron, Social Worker
- Lt. Lance Burnham, Vermont State Police
- Amy Torchia, Children's Advocacy Coordinator, Vermont Network Against Domestic Violence and Sexual Assault
- Jacqueline Corbally, Clinical Services Director, Vermont Department of Health (VDH)
- Kim Coe, Director of Residential and Community Treatment Programs, Lund
- Charlie Biss, Director, Child, Adolescent and Family Unit, Vermont Department of Mental Health
- Joanne Wood, M.D., M.S.H.P., Assistant Professor of Pediatrics, Perelman School of Medicine, University of Pennsylvania
- Dr. Breena Holmes, M.Ed., Director, of Maternal and Child Health Division, VDH
- Beth Tanzman, M.S.W., Assistant Director, Blueprint for Health
- Sally Borden, M.Ed., Executive Director of KidSafe Collaborative, Children and Recovering Mothers (CHARM) Team
- Sally Fogerty, M.Ed., Director of Children's Safety Network
- CECANF staff: Dr. Rachel Berger, Hope Cooper, and Tom Morton

COMMISSIONER MARTIN: ...The second thing I would like to announce is that you probably know my name is not David Sanders. Commissioner Sanders is the Chair of our Commission. Unfortunately, he is having difficulty with the weather, as are some of our other Commissioners. So what we are going to do this morning is I am going to allow the Commissioners who are present to introduce themselves, and the ones on the telephone to introduce themselves. Throughout the day I will keep you abreast of our schedule. I have a couple of speakers who may or may not be able to get in today as well. So I will keep you abreast of how that is going.

At this time, however, I would like to allow the Commissioners to give a brief introduction. Why don't I start from my far left?

COMMISSIONER AYOUB: I'm Amy Ayoub from Las Vegas, Nevada, where the weather is just a little bit different today. I am a child advocate. I am a sex trafficking survivor, and look forward to hearing testimony today. Thank you.

COMMISSIONER COVINGTON: Good morning, my name is Teri Covington. I am the Director of the National Center for the Review and Prevention of Child Deaths. We support states and local communities in their reviews of fatalities, and I am very happy to be here in Burlington. I love it here

COMMISSIONER RUBIN: Good morning, I'm Dr. David Rubin. I'm a general pediatrician and the Co-director of the PolicyLab at the Children's Hospital of Philadelphia.

COMMISSIONER HORN: Hi, I'm Wade Horn. I'm a clinical child psychologist and I'm with Deloitte Consulting.

COMMISSIONER MARTIN: And do I have any Commissioners on the telephone this morning?

COMMISSIONER CRAMER: Yes, this is Bud Cramer.

COMMISSIONER MARTIN: Thank you, Commissioner Cramer.

COMMISSIONER CRAMER: Good morning. I'm a former member of Congress, former prosecutor and (inaudible, recording skipping).

COMMISSIONER MARTIN: Thank you, sir.

CHAIRMAN SANDERS: This is David Sanders. I anticipated being there but I hopefully will make it there by early afternoon.

COMMISSIONER MARTIN: Thank you, Commissioner Sanders. Anyone else?

Very well. Ladies and gentlemen you are here for a hearing for the Commission to Eliminate Child Abuse and Neglect Fatalities. What I would like to do is kind of outline the purpose of our meeting before we began. Really, our purpose today is to talk about the child abuse and neglect fatalities in Indian Country, when a child welfare staff misses warning signs in the welfare of one of our children, the state-of-the-art of safety assessment here in Vermont and nationwide, and a public health approach to preventing child abuse and neglect fatalities.

I will be a little strict with time, and I apologize up front. We have a tight agenda today and in an effort to allow all our speakers to present, I will try to be as reasonable as I can, but please note that I may have to cut you off and I apologize for that. I will also indicate to you that the audience members will not have an opportunity to ask questions. However, the audience members are invited to leave written testimony with the staff that will be presented or distributed to the Commissioners after the hearings this morning. I will also indicate to you that if you have not registered at the registration table please do so, so we know who is present, and please let the staff know if, in fact, you intend to submit written

testimony before the day is over. I will also ask that each and every person, speakers as well as Commissioners, speak into the mics. This meeting is taped and it has to be clear, so if you can speak in the mics we can make certain that taping is done.

At this time, I would like to present and introduce our first speaker. I will not take time to go through their bios. The bios are available to everyone present today. I will let you know which speaker will be coming up and I will give you your time frame in which to speak. Tammy Simoneau will have about 10 minutes to speak with three minutes for panel discussion and Commissioner questions after each speaker at the end of their presentations. So why don't we begin with you and allow you the opportunity to address the Commissioners at this time.

TAMMY SIMONEAU: Hi. My name is Tammy Simoneau. I am a foster parent and adoptive parent. I live in Newport, Vermont. I relocated here from sunny southern California back in 1993.

At this point in time, I have four biological children ranging from 20 to 26, and then we adopted two children with severe special needs. My second daughter also has developmental delays, high functioning, which allowed us to learn how to navigate the system of Vermont and how to access services, which kind of led us down the road of being able to adopt the two that we have.

My daughter, Madison, is 13. She was a victim of shaken baby [syndrome] at five weeks of age. She had to be intubated and resuscitated three different times upon her injury. After scans, she was found to have been shaken probably at least three times prior to her five weeks' time, which put her into complete respiratory arrest.

My son, Jaden, is nine. He was a victim of failure to thrive and medical neglect and was born with a condition called Hemimegalencephaly, which caused him to have several brain surgeries, and by the time he was two and a half, he had to have his whole right hemisphere removed and a shunt placed. Due to the inexperience of his mom and just being very young, she wasn't able to meet his needs and suffered severe delays.

Both children have impacted our lives and our community's lives by just being around. Neither of them were expected to survive as long as they have. We have fostered other children with shaken baby and we are currently co-fostering with my oldest daughter a shaken baby who is currently in the hospital with complications due to a shunt.

Our concerns with everything that has been going on is kind of a lack of education in the system when it comes to these kids with special needs, and that involves the social work staff and the Department of Children and Families (DCF), and also the lack of education in the parents themselves.

You know, as we know, the brain is kind of the mainframe computer of your body and when that gets broken, it affects all the other parts and functions. My daughter Madison has been left with what they call a left-sided brain melt, so if you look at her brain scan she has no brain tissue on the left side, it's just black space, and she lost about 50% of her right side because of the violent shaking. This child went without appropriate intervention services for the first eight months of her life because the social workers weren't really informed on what was out in the community for that first foster family to support them and get the services needed. Living in Newport, Vermont, services are very limited and inaccessible, but they are

out there if you know where to look and how to access them, and it takes a lot of footwork and dedication. She is completely hands-on care and requires complete assistance in everything she does, and in the course of going through puberty has had a real backslide in her health.

When we received Jaden, he was at a person's home, locked up in a port-a-crib, kind of just left floundering when we got called on him. He had been in custody one other time before they called us. He was pulled into custody at 18 months of age, relinquished back to the birth mother, and then underwent placement with us at four and a half.

So the concerns around education are, I really feel, the need for more social workers to be hired to allow less of a caseload and for them to learn more when these high need kids come into custody. I also feel that as foster parents we are required to meet a certain expectation of what is required of us for care. A case plan is always put in place with parents. It seems to be the minimum amount of what they are required to do to get their children back, and as foster parents it is frustrating because we feel like they should be challenged with the maximum amount of what they need to learn and do.

We were placed with a foster child at 10 weeks of age. We spent a week with him in the hospital after being violently shaken, with unknown perpetrators, between the father and the mother. The plan was adoption. We brought him home at 11 weeks old. He was gray and swollen. During that course of time we were told we would get to adopt at six months' time. The investigation by the social workers found and changed the percentage from 50/50 chance that it was either parent to a 51% chance it was the dad and a 49% that it was not the mom. From that time, they switched the case plan to reunification, and it took them an additional 14 months to replace this child back with his mother. We were asked to participate in the development of that case plan. We developed a strong case plan to acknowledge education and child development, brain function, how brain damage affects development in children, and as time went on our kind of expert opinion kind of went down to personal opinion, "That's your personal opinion that that is happening."

So that was frustrating on us. We are one of the few families that is willing to accept children with special needs because of our background and training, and for us it is all about the kids and how to make them have quality of life, how to make them loved, and be most successful.

At this time, that child that was replaced to his birth mother got him back. We still see him the majority of 50% of the time because we offer ourselves up for childcare so we can keep track of him. I think the other frustrating part with that was this child suffered a traumatic brain injury. He also suffered 13 broken bones that was not related to the shaking. And in the course of all this development, none of the broken bones were ever looked at as a concern; it was just all about the traumatic brain injury.

So I really feel that education on both parts really needs to increase. I feel like working with medical staff needs to be more involved by the social workers. We have been told by social workers in the past that it is not their job to attend medical appointments, and I don't understand how a program can advocate for children in their care and that they are guardians of if they don't have a full understanding as to what that background, those expectations and the underlying conditions of that child is going to be. When you damage a brain it affects all the other parts of the body function, like I said and you are left in a "what if" world and an unknown world of development. So you never know how this child is going to develop, you

can't predict based on the amount of brain damage because every child is different. The brain is a phenomenal thing on how it rewires. We have worked with several children from the severe brain damage that requires hands-on care and then to the other piece. So as a parent I just would really like to emphasize the need to expand the maximum training across the board and also to make sure that advocacy is increased in knowledge of what these kids are expected of.

Thank you.

COMMISSIONER MARTIN: Thank you so very much. Are there any questions from Commissioners? Please.

COMMISSIONER RUBIN: One question. I mean, it sounds like you have had a lot of exposure to victims of shaking, right? And I don't know how much you know about their prior histories, but when you look back and you understand their histories before they were shaken, were there opportunities to prevent it? Were there interactions with medical, or child protective services (CPS), or other programs or WIC [Special Supplemental Nutrition Program for Women, Infants, and Children] where you felt like there may have been an opportunity to prevent that child from being injured?

TAMMY SIMONEAU: With my daughter, yes. She had a sibling from the birth father that had suffered a parietal skull fracture from being slammed into a corner of a wall and a spiral fracture that was left untreated. Neither parent was charged because, again, it became inconclusive as to who was the perpetrator. He went on to father another child with that same woman and that child was pulled at birth. He fathered this child with a different woman, but because the woman had no prior issues with DCF that family was never flagged. The pediatrician did warn the birth mother and notified DCF that there was a baby, and notified the mother that the father was a violent offender and had history and there was no intervention. So yes, I feel like if DCF would have gotten involved and maybe flagged that family and got involved a little more, maybe she could have not suffered what she suffered.

In my son's case they did intervene at 18 months. She got him back but he wasn't stable and she wasn't stable so again, I think that him going back would put him back at risk. I think that more intervention and closer ties and looking at that would have been better.

I also feel that with the other one that we fostered that got relinquished back to the birth mother shouldn't have taken an additional 14 months for them to prove her capabilities of caring for him, and they kept extending things and he is still high risk.

COMMISSIONER BEVAN: I'm sorry I'm late. You said the second child was pulled at birth. Do you mean that the child was removed and then placed right into an adoptive home? Was there a bypass of reasonable effort so that the child could get moved immediately?

TAMMY SIMONEAU: Yes, my daughter, Madison's birth father's second child was pulled at birth because they were high risk because of the domestic violence in the family and was placed with the maternal grandmother. Since that time, I believe, to the best of my knowledge that she is still there. I don't know that much about it. I mean --

COMMISSIONER BEVAN: So you don't know what the safety plan was. Has anyone mentioned to you the Adoption Safe Families Act, the fact that children are not supposed to stay in

foster care more than 15 out of the past 24 months? There are circumstances such as the ones you described where the child should not be in foster care for an extended period of time.

TAMMY SIMONEAU: Well that was our hope with the last foster child that we had and we kept bringing that up as far as the permanency plan that the plan would be in place.

COMMISSIONER BEVAN: And a safety plan.

TAMMY SIMONEAU: And a safety plan would be put in place. What we saw was that the birth mother's mother is a very influential person in the community and when the social worker told the birth mom that she could do certain things but did not get permission from the team, then he had to renege on those things and it became a very political situation. The grandmother called the Commissioner and the mother called the Commissioner and it became a very political thing. We were told by DCF that they were told to make this go away, and make this happen. So they proceeded with meeting the minimum requirements, and as long as she was showing minimum improvement the plan was for this child to be returned, and he was after 20 months.

COMMISSIONER MARTIN: Let me take this opportunity to afford the two Commissioners who came in to introduce themselves.

COMMISSIONER BEVAN: I'm Dr. Cassie Statuto Bevan. I worked on Adoption Safe Families Act and many other of the children's rights laws, and for the safety laws for the past 20 years on top of the hill, and I'm very sorry to hear the way it has been implemented.

COMMISSIONER MARTIN: Commissioner Petit?

COMMISSIONER PETIT: Yeah, I'm Michael Petit. I'm the President of Every Child Matters, a national advocacy group for kids. I was formerly with Child Welfare League of America [CWLA], and at one point was Maine's Commissioner of Health and Human Services.

COMMISSIONER MARTIN: Thank you. Any further questions? Oh, and please introduce yourself.

COMMISSIONER RODRIGUEZ: I'm Jennifer Rodriguez, the Executive Director of the Youth Law Center, and thank you for your testimony.

COMMISSIONER MARTIN: Are there any other questions from Commissioners? Please.

COMMISSIONER AYOUB: First of all, thank you so much for what you are doing and the difference that you make. I appreciate it. You said that you would like to see more social workers to relieve the caseload so that then they could get training. Do you think that is what would happen if there was more social workers or do you think that there should be a mandatory training before they are hired?

TAMMY SIMONEAU: I think a combination of both. I think, in seeing the caseloads, and unfortunately the number of children that are coming into custody I think they get inundated with the needs. I think the philosophies have changed to try to keep children with the families as much as possible, but when you have these children coming in that are high risk and high need because they have been shaken or severely abused that puts their medical

need different. I believe that training should take place prior to as far as expectations. But when we get called, we usually get called last minute because these children are in the hospital, usually on a respirator, not expected to live, and so they haven't prepared a foster family placement because they are being told that this child probably will not survive.

They take the child off the respirator and children are resilient, as they have proven time and time again, and all of a sudden they are scrambling to find a placement. We have been asked to take a child that has been in a residential facility right now for six months because the old foster family did not want him back after a serious medical episode, and he has been institutionalized for six months because they could not find someone to take him, so we have been asked to take him on, which for us it is all about the children. Medical stuff and those things don't make us nervous. But it is scary when you have a social worker tell you, "I'm sorry, I don't have to attend that medical appointment because that's not my job." I just feel that if there was more social workers and ones trained in the specialties per office, at least one that could handle those high medical needs, then maybe the approach would be a little bit more aggressive and different in how they would look at those case plans for reunification if that's where it was to go.

COMMISSIONER COVINGTON: I'm not sure, really, how to ask this question, but as you are talking about both of your children who have really severe needs, serious needs, and we are focused on fatalities, we actually have a presentation this afternoon that talks about near-fatalities, some children who have really suffered serious injuries. With your children, and I don't really know a lot behind their history in terms of what happened, but do you think there is a difference between them and children? What kept them alive, and are there any lessons we can learn from that? And do you think that there is a difference in focusing on just fatalities as compared to children with serious injuries and fatalities.

TAMMY SIMONEAU: I can't answer what kept them alive. I think technology is a big part of that. They go into hospitals and they get amazing medical care now with today's technology. I think resiliency. They evidently want to be here for the fact that they fight to continue to be here, with the hopes that there will be someone out there to care for them. I think we have made a difference in their survival rate because of our quality of care and our ability to advocate and get second opinions and if we are not happy with the doctors seek teams out elsewhere. We are very diligent about where our kids go and who they are placed with, and getting them the best care possible, so we work with our local team in Newport.

But then we work with a Fletch Alan team, we work with a Dartmouth team, and we have a Children's Hospital team in Boston. So we travel to get the needs met.

I'm not exactly sure, but I think that it's not just about fatalities because if you have a child that is injured to the severity they pass on then you hope you can get justification if you can find out who the perpetrator was and seek justice. When kids are injured to the point where they survive they are given a life sentence of disabilities where they were born perfectly normal children. The children that we have that dealt with that have been shaken at, you know, five weeks of age, 10 weeks of age, both with prior experiences of being injured that did not get flagged or looked at, and then this other child that we are co-fostering right now that is in the hospital was five and a half months, perfectly developing, meeting all his milestones and they consider him a shaken impact, so shaken, slammed on a hard surface, and possibly smothered. Why that late in time?

So I really feel that more justice needs to happen and relooking at those pieces too as to the need and the care for long-term, because those kids still are around. They didn't pass on. So I hope that answered your question.

COMMISSIONER RODRIGUEZ: I have a question for you. It has been my experience, in talking to other foster parents that they often have more information than anybody else on the case when a child is being reunified about some of the safety conditions that may exist in the home and also the child's needs and vulnerabilities. I'm wondering systemically for you and any other foster parents that you know, to what extent are you consulted when a child might be returning home to a family where there is abuse and you have concerns about safety. Is your input sought out by child welfare? Do you have an opportunity to tell the court? What are we doing to get the information that is really valuable in thinking about the risks?

TAMMY SIMONEAU: We did not have an opportunity to talk to the court. It depends. It is social worker-based. It depends on which social worker you have on each case as to what is supported and what information they are looking for. There is a variety of guardian ad litem that are supposed to advocate for children.

We had a fantastic guardian ad litem with our daughter, Madison, who came, observed, went to the home, observed, and did a fantastic job. We had a guardian ad litem that had medical background with the foster child that was relinquished back to the mother who had medical background. She relinquished her time because she didn't have time to stay on. She was a doctor. It got presented to another person who was very nice but not a strong advocate for the child.

We are currently working with a guardian ad litem now with our current foster child who has been in placement with us since May, and we have yet to meet them, hear from them, see them or anything to advocate. We were asked to participate in the case plan for the young man that got reunified, and like I said, that was good until I started questioning saying, "Well why isn't this happening in the case plan? Why isn't she attending a parenting class? Why isn't she getting certified in CPR or first aid? Why isn't she learning about seizures?" That's all part of the case plan as to what they wanted to do. And the more waves I made the more my professional or expertise in him became an opinion, and I just needed to accept that he was going home and there was nothing I could say or do to change that. Accept it and move on, which is fine, but at that point, when I get a call when I'm in a hospital with another child from this same birth mother that says, "Tammy, I am so sick I can't take care of my son. When are you coming home?" that's a concern.

We all, as parents, get sick. We have to take care of our children. We don't have someone to call. I came home from the hospital to take him and had him for two nights because she felt she couldn't care for him. She had an "out", she had a way. DCF could have resolved that. He could have been in a safe environment. At least she called, that's what I have to be thankful for.

COMMISSIONER MARTIN: Commissioners on the telephone, do you have any questions?

COMMISSIONER CRAMER: No, I just wanted to say I respect the role that she's playing and what she has been through. I have no questions. Thank you.

COMMISSIONER MARTIN: Very well. Thank you so very much for coming in and providing your testimony and your story to the Commissioners this morning. We do certainly appreciate your willingness to open up about your family.

TAMMY SIMONEAU: Thank you very much for having me.

COMMISSIONER MARTIN: Thank you. Ladies and Gentlemen, our next speaker this morning. Good morning, how are you?

CINDY WALCOTT: I'm fine, thank you.

COMMISSIONER MARTIN: Very well. Before you get started we have one other Commissioner who has not had the opportunity to introduce herself. Did you? I apologize, she did. Okay. Very well. Our next speaker, ladies and gentlemen, is Cindy Walcott. She is the Deputy Commissioner of the Family Services Division for the Vermont Department of Children and Families. Thank you so very much for being here and you can begin when you are ready, ma'am.

CINDY WALCOTT: Thank you very much. It's nice to be here and wonderful to have an opportunity to learn along with you today. I would like to appreciate Tammy Simoneau's testimony and giving, really, a face to all of what we are talking about this morning. I was asked to speak a little bit about what efforts Vermont has been making to prevent child fatalities due to child abuse and neglect. So I think the first thing that is important to think about in the prevention of child fatalities is to understand what we are trying to prevent and what nature of child fatalities. In Vermont, we try to make sure that we are reflecting on what is happening to whom and by whom, because that helps us to target our efforts. We have a relatively low rate of child fatalities in Vermont, which in some ways makes things more challenging in terms of the kind of expertise that Ms. Simoneau was talking about among our staff. If you don't encounter a situation very often then you don't have the skills and knowledge to deal with it as effectively as you might wish.

So from 2007 to 2014, 20 children have died from child maltreatment in Vermont. Some years that figure has been zero. The highest figure has been five. The most common cause of death has been abusive head trauma, and Ms. Simoneau certainly talked about the reality of children who survive that kind of injury.

So 10 of those 20 children died from abusive head trauma. So the next question that seems relevant is who were the perpetrators of that kind of violence to children? And what we find in reflecting on that is that seven of the abusers were male, two were undetermined, and Ms. Simoneau talked about that; not being able to determine whether the mother or father was the perpetrator. One was female.

The second most common death, and this only accounts for two children, was due to unsafe sleep practices. Now we don't always substantiate unsafe sleep practices, but if the parent is impaired and that was a factor then we would. Both of those children were sleeping with the mothers.

Then lastly, 16 of the 20 children who died were under the age of two. So what we have been doing, primarily, is focusing on prevention of abusive head trauma, on understanding the roles

of fathers and what we need to do to strengthen the role of fathers, and also the issue of safe sleep.

For over 10 years here in Vermont, the child welfare agency, the health department, and the developmental services agency have been funding a prevention program that is delivered by Prevent Child Abuse Vermont (PCAV). I think these programs exist around the country, but here are just a few little statistics on what was accomplished during 2013. I think it is important to note that all 12 Vermont hospitals who have maternity units do participate in this. It's not just you are handed a piece of paper. In most cases there is a discussion, the parents view a video, and in nine of the hospitals, the parents sign a pact, essentially, not to shake a baby. So that has been helpful and long-standing. Prevent Child Abuse Vermont has also been working with pediatric and family practices, the same kinds of issues of preventing child maltreatment or abusive head trauma.

This just shows you the link to PCAV's materials so if you want to go and look at the kinds of materials that they have up in their website you can do that. I think it is important to note that a lot of the graphics that they use show fathers. I just think that is reflective of the fact that males are most commonly the perpetrators of this and attempt to really recognize and support fathers in trying to cope with crying, learn how to soothe children, and these kinds of things.

Secondly, we have had a focus on engaged fathers. I think most of us that have been in child welfare for are careers know that we have been pretty focused on mothers for most of the time, and fathers have been very much left out of the equation. But the fact of the matter is that children are in danger from their fathers, so we have really been trying to focus on the role of fathers, so we have done staff training that helps our staff to understand how fathering is different from mothering. Sometimes I think we look at fathering through a mothering lens in child welfare, and fathers interact differently, and in very positive but different ways than mothers do. So we want to support that and be able to really see more of that positive fathering behavior.

We also have really worked on fine-tuning our approach to domestic violence and families experiencing domestic violence, and trying to understand how we can better support safety of all family members without totally excluding the father, but by bringing him into the equation. I think one of your other witnesses later today will be talking more about the Safe and Together approach, but I gave you a link here if you are interested in more information.

We also, for the last three years, have had statewide fatherhood conferences, which have been held to focus on the issue of responsible fathering.

Promoting safe sleep, as I said previously, not all children who die from unsafe sleep practices are considered to be victims of child abuse and neglect. However, we always get reports about those and we are very concerned about the degree to which children die from unsafe sleep.

So in 2012, we asked the Vermont Department of Health to develop a one-page, easily digestible tip sheet for parents, and they did in rapid order. And since that time we have had policy in place that requires our social workers to give this sheet and to discuss with parents the information on the sheet with all parents that we are intervening with and who have a

child under the age of one or who are currently pregnant. Here is a link to the tip sheet, should you care to look at it, and you actually have it as a handout as well.

Supporting parents with young children. I happen to believe that this is one of the keys to preventing death due to child maltreatment. We have to get to parents sooner and we have to provide them with the kind of support that they need so they have good knowledge of child development, they have adequate support systems, et cetera. So in Vermont, we do have 14 parent/child centers who are working in their communities to help families with young children. We also, about 10 years ago, brought together a formerly free-standing program, Healthy Baby, Kids and Families, Children's Upstream Services, which is an early children developmental health program, and also our Family Infant and Toddler Program, which was our Part C funded services, into an integrated program called Children's Integrated Services. Each of our district offices has a coordinator of Children's Integrated Services and a parent or professional can contact that coordinator and they can be directed to the right service in their community. So that is something that I believe is strong in our state, and that kind of integration has really helped more families to get the kind of service and support they need.

We have implemented the Nurse/Family Partnership with Affordable Care Act funds, which is great. We are also working in this state to understand the application of Strengthening Families' framework to our work. It has been great because we have been able to really begin to develop a common way of thinking about support to young families, and I think that has been positive.

As far as the child welfare agency goes, we have made a number of changes, which have really been designed to help us to get to families sooner. In 2008, we expanded our criteria for accepting a report for child safety intervention with really a much-increased focus on the patterns of concerns that happen over time rather than does this incident or this allegation sort of meet the threshold. So in our centralized intake operation we always look back at history and use history to determine whether we need to send a social worker out now. So as a result, our child protective interventions did double over a three-year period, so I think that is pretty significant. We implemented differential response in 2009. About 40% of cases are now handled as assessments, which is not as high as in some states, but because Vermont has a role in sexual abuse by non-caretakers, we have a very high level of accepted sexual abuse and those were all handled as investigations.

Also in 2009, concurrent with implementing differential response, we realized that we really needed to take advantage of research that says substantiation is not a good predictor of future child maltreatment. So we de-linked our criteria for opening a case for ongoing family support services from the substantiation decision and now rely on a validated risk assessment tool to determine whether or not we will offer services for ongoing support. As a result, our open family support cases increased by over 500% in one year. So we are really trying to reach families sooner, more assertively, more supportively and are trying to address the developmental needs of the children and families.

So just in conclusion, I strongly believe that in your deliberations, you should be looking way beyond the role of child welfare, and I'm sure you are. Child welfare really does not hold the key to preventing child fatalities due to maltreatment. By the time families come to our door they are in a lot of trouble. I will say that in Vermont, over the last 18 months or so, the use of opiates has risen steeply. It has changed the safety equation for us, and quite frankly, we are still catching up with what that means to us and what we need to really be doing

differently in terms of decisions about safety. It is very hard for a government who is used to sort of cleaning up after the messes, intervening when something has already happened, to really take the courageous step to take some of those funds and invest them in services that might avoid the problems of the future. But after 37 years in child welfare I strongly believe that we have to find the courage to do that. We certainly know that the federal financing scheme doesn't support that. Federal funding is maximized for out-of-home care and other deep-end interventions and is pretty skinny when it comes to avoiding the problems in the first place and trying to keep families together and safe. So that is something that has been on my mind a lot in the last nine months as we have gone through a pretty tough time here in Vermont related to child fatalities. I hope that we will be on your list of things to consider.

COMMISSIONER MARTIN: Thank you so very much. Commissioners, please?

COMMISSIONER AYOUB: You just mentioned the rise in the use of opiates. Is that because of the behavior of the parents or the children being born to parents that are using opiates?

CINDY WALCOTT: I'm not sure I understand your question entirely. Are you saying why do I think the safety equation has changed?

COMMISSIONER AYOUB: Yes.

CINDY WALCOTT: It is, yes, it's the parents' ability to prioritize the needs of children over their addiction.

COMMISSIONER MARTIN: Commissioner Horn?

COMMISSIONER HORN: First of all, as the co-founder of and former president of the National Fatherhood Initiative, I want to thank you for your work here on focusing on fathers. I remember being up here with Con Hogan many, many years ago. I think our paths may have even crossed.

CINDY WALCOTT: I think they may have.

COMMISSIONER HORN: So it is terrific to see that you are continuing that kind of work and that focus. Of the 20 deaths, do you know how many of them were known to the child welfare agency prior to the deaths? I'm trying to get a sense about is there an intervention point before that that could have happened? So how many of those do you have a sense of that?

CINDY WALCOTT: I don't have that exactly, Commissioner Horn. If I had to ballpark it, I would say probably about half.

COMMISSIONER HORN: Okay, thanks.

COMMISSIONER MARTIN: Commissioner Bevan.

COMMISSIONER BEVAN: Thank you for your testimony. I too have been in child welfare for 30-something years. I have seen the cure de jour swing over the years.

CINDY WALCOTT: Yes.

COMMISSIONER BEVAN: Child welfare seems to be particularly susceptible to finding a cure. You know, family preservation and then back and forth. So I am very concerned about differential response. You initiated it some five years ago. Do you have evaluation results in terms of how it works and how it has been working?

CINDY WALCOTT: No, we have not had a formal evaluation.

COMMISSIONER BEVAN: I'm concerned about why you think that substantiation is not a good predictor. I mean, there are risk factors that are a good predictor.

CINDY WALCOTT: There is research out there that indicates that people that have experienced a substantiation are not substantially higher. They are more likely to come back in the future with maltreatment. So this is not something that I've made up.

COMMISSIONER BEVAN: No, no, no. I wasn't suspecting that. So my concern is, with the differential response, it is an assessment that is made, it's not an investigation, right?

CINDY WALCOTT: Yes.

COMMISSIONER BEVAN: Can you walk me through it? How, exactly, does it work? How do you not investigate?

CINDY WALCOTT: Investigations and assessments actually look quite similar on the ground, because a good investigation focuses...you know, you have to focus on an incident, if there is one, in an investigation, because you have to make a substantiation decision. But in my opinion, the important part of the intervention really has to do with understanding what is going on in the family, what the stresses were that brought the family to this point, and what can be done now to address those so that parents and families can get on the right track. Those are the essential elements in either an investigation or an assessment.

COMMISSIONER BEVAN: Do you have any concern about this increase of over 500% in one year in open family support compared to the number of social workers you have? I mean, it seems that you are going rather thin on the social workers and I'm concerned about the fatalities.

CINDY WALCOTT: Sure.

COMMISSIONER BEVAN: So I'm very concerned about are you running thin and not getting to them?

CINDY WALCOTT: We actually have added social workers during that period of time. In Vermont we started before this with about 150 social workers, just to give you a little bit of perspective; very different from other states. So we have added over 30 social workers during that period of time. Is caseload a concern? It's a concern in any child welfare system, but we have, at two different periods of time in the last five years, been able to add a substantial number of social workers from a percentage perspective, and most recently just this summer.

COMMISSIONER BEVAN: Thank you very much.

COMMISSIONER MARTIN: Commissioner Rubin?

COMMISSIONER RUBIN: When we look at child fatalities or near fatalities, we often ask, "How many of these kids were 'known' to CPS?" This is not a Vermont-specific question. We get differential response or an alternative response, which is a little bit more on the services side, routing kids out of the system. Do we have the ability to say, "Which kids were known to differential and alternative response?" I want to unpack what it means to be "known" to CPS, because my worry with differential and alternative response is there is no flag there when the kid comes back.

CINDY WALCOTT: Oh no, we absolutely know. And I'd like to challenge something you said, actually, if I may. In Vermont, I don't know about other states, but differential response is not designed to divert families from the system. We have the same ability to approach the court for a child to come into custody if we are in the assessment track as we do in the investigation track. We have the same ability to provide and open a case for ongoing services. We have the same ability to refer the family to appropriate community resources. So it is not a diversion.

COMMISSIONER MARTIN: Unfortunately, we have few minutes left and I have other Commissioners with questions. So I believe they are going to have to get to you during the break to ask those questions.

CINDY WALCOTT: I will be here.

COMMISSIONER MARTIN: Thank you very much for your testimony. We really do appreciate it.

CINDY WALCOTT: You are welcome. Thank you so much for the opportunity.

COMMISSIONER MARTIN: Ladies and gentlemen, our next presenter is going to focus on and explore about the prevalence of child abuse and neglect fatalities among Indian nations. I'd like to present to you Mr. Terry Cross. Good morning, sir, thank you so very much for coming in.

TERRY CROSS: Good morning, thank you for inviting me. It's an honor and privilege to be here to speak with you. I want to take the time this morning to give you some background and say hello to a few of the Commission members that I know personally. It is good to see you again.

My name is Terry Cross. I am the Executive Director of the National Indian Child Welfare Association. We were founded 31 years ago today and I am the founding Executive Director. This is my 42nd year in child welfare. I was knocking on doors and investigating child abuse and neglect when I was 21 years old. And I wonder today how they let me do that, but I had a great supervisor.

Today I am going to address the historical context in which tribes are responsible for dealing with child abuse and neglect, some of the current status of the data issues, and some of the legal and jurisdictional issues that make this work very complex in our tribal communities. I'll give you a picture of the policy and funding challenges that tribes have as well as looking at what some of the needs are for collaborative responses to deal with this complex set of issues, and a little bit about what tribes are doing and offer you some questions that I hope you can pursue as a Commission. Because just what I have to say today, I hope lays the

groundwork for your interest and not the end of the discussion because this is a serious issue in our communities and as is all of child abuse and neglect.

First of all, I would say that I really have to make sure that I state clearly the diversity in Indian Country, the range of the differences geographically, culturally, economically and the history. I am a member of the Seneca Nation of Indians from the Allegany Reservation in western New York State. Our tribe has had contact with Europeans for 400 years and I live in Portland, Oregon. That is where headquarters are, in the Oregon tribes. Their treaties were from 1855. So it is a very different relationship and I just got back from Alaska, where in many of the villages where we work the history is less than 100 years. There are urban populations. Almost two-thirds of our tribal people live in urban areas. The government structures of tribes are very different; about half of all tribes have their own tribal courts. There are major size differences. The whole River Tribe in Washington has 50 members, the Navajo, 500,000, so everything in between.

There are land-based tribes and landless tribes, and a history of relationship with the United States government and colonial powers pre-dating that relationship that is very problematic with layers of federal/Indian policy that keep complicating the difficulties in our community. And I want to say that to understand this history, it is important to understand that any colonial power in the world, and I count the United States as a colonial power, has to do five things to control the indigenous population of the place where they take possession. They have to take the land, they have to take and control the natural resources, particular access to food and water, they have to usurp the governments, in other words replace the governing structure of the indigenous people, they have to delegitimize thought, culture, language, religion, and finally they have to take the children. Because taking away the children so disrupts the social fabric of a people that it dismembers the culture to such an extent that it is nearly impossible to put it back together. And as early as the Virginia Company's authorization of kidnapping of Indian children to save and civilize the Indian, all the way to the boarding school era, and the current over-representation and foster care, the pattern continues.

I'll talk a little bit later about the number of children who were raised in boarding school. Just to give you an idea, in 1972 there were literally American Indian communities in the United States that had no children. Imagine that. Communities with no children, because the United States government thought that the American Indian children were better off outside of Indian culture. The eras of our history from pre-colonial times to the period of coexistence were actually quite long, about 300 years from the time the Europeans arrived until about 1830 when a decision was made to eliminate Indian people, and you all know about the Trail of Tears, but there are many, many more. In 50 years the estimated numbers of loss of people on this continent was about 75 million native people who were killed, died of starvation or disease, sometimes introduced intentionally. This is America's shame, something that we don't hear about, something we don't read about in the textbooks, but something that leaves a legacy of trauma. And people say to me, "Why don't you just get over it?" My response is, "Why don't you just stop it." because it continues to this day. The cultural genocide, if you look at the last nine Supreme Court decisions with regard to American Indians, they are still taking our land, still taking our natural resources, still delegitimizing our thought and our governments, and still taking our children.

So I am here to talk about this legacy, to understand the influence of boarding schools, the Allotment Act, Public Law 280, the Arena Project, and many other policy issues. And it is only

today the tribes are beginning to recover and beginning to create their own solutions because we have come to realize if we don't solve this historic trauma ourselves we will cease to exist. To feed a new (inaudible), a community healing person from the Black Feet nation says that colonization dismembered our people, dismembered our families, our life ways and our job today is re-member.

The period of forced assimilation and the boarding schools was followed by a period humanitarian assimilation which included relocation from reservations to urban centers, the Arena Project that placed hundreds of American Indian children in non-Indian homes through the Child Welfare League of America and then taught states and counties and private agencies how to do that. The Public Law 280 that was a wrongful taking of jurisdiction. But finally, in the late '60s and early '70s, it initiated a new federal policy of self-determination and the recognition that Indian people weren't going to cease to exist and if we were going to be successful, we would need to govern ourselves. So since that time, just 10 years longer than my social worker career, and not even that, we have had tribes taking over their social services in a series of pieces of federal legislation that has enabled tribes to do that. As you can imagine, the historic distrust that comes about in this environment is tremendous. And because of the way that the legislative frame has emerged over time, tribes have not had access to the same service structures and funding structures that states and counties had. So the service development had lagged behind and we still see that today with tribes not being eligible for certain federal funding streams, most particularly, title XX.

We don't know enough about the risk factors that impact American Indian children. We know what the mainstream risk factors are and we know that if you apply those risk factors in our community we have far too many of them; deep poverty, substance use disorders, trauma, depression, poor housing and lack of education. But we don't know enough about child abuse and neglect in our communities. Unfortunately, the National Incidence Study excluded Indian data. They gathered data on some Indian people, and I have to say there is no greater slight to a people than to say, "There is not enough of you to count." In what society is that okay? Really, only in a post-colonial society that believes that its indigenous population is worth throwing away.

So data is not reported on Indian children because there isn't a structure to do that. There is no coordination across agencies that have data. We need a closer look at risk and the data. And I will come back to this a little later, that is, the NCANDS database represents perhaps about 60% of the data out there because of the way that services are structured and because tribes don't report to the NCANDS database and have no mechanism by which to report to the NCANDS database.

I want to talk a little bit about the risk factors that we do know about in Indian Country. About 34% of our children live in households that would be considered impoverished. I participated in a study, and probably most of you know Christie Nelson. Christie was the principal investigator of study of child neglect in Indian Country, and NICWA ran the Oregon site and Christie the Iowa site. We looked at families, half of whom had a confirmed history of neglect and half who had no history of neglect but were matched by per capita income. What we found was it wasn't simply poverty or wasn't per capita income that influenced whether or not neglect occurred, but it was the depth of the poverty.

If you didn't have transportation, if you didn't have a washer and dryer, or if your roof leaked and you didn't have adequate housing, the more of those things that you added on the higher

the rate of neglect. And if you put into the mix victimization or depression then you begin to see the neglect emerge. Interestingly enough in that study, the neglecting sample actually scored higher on parenting skills than the non-neglecting families. It does say something about needing a public health response for families to avoid the problem of neglect.

About 18% of adults need treatment for drug and alcohol problems, so substance abuse is a major problem, and we estimate somewhere around 80% or higher, 85% of child abuse and neglect is substance misuse related.

Substance abuse is a very difficult problem in the country, and most people are aware that we have the highest rate of substance abuse, and in particular alcoholism of any ethnic group. But few people are aware that we also have the highest rate of abstinence of any ethnic group in the country. There is not a lot of middle ground. We don't have a lot of social drinking in Indian Country. Not a lot of "wine and cheasers" out on the reservation. As I travel out in tribal communities, I'm hearing 95% to 100% of their child welfare cases are substance abuse related.

Our American Indian families are much more likely to struggle with mental health issues and distress of unresolved trauma. We have the highest youth suicide rate in the nation. We have the highest rate of serious psychological distress and depression episodes, and of depression and victimization being closely associated with child neglect.

I mention this long history of trauma, this long history of oppression, and so I would ask you to think for a moment, and I am a science fiction fan, I go to the movies to see the science fiction movies. In recent years, there have been a lot of movies about aliens coming and taking away the freedoms of the people who live here. But imagine for a moment if an alien force came here and said, "I'm taking your land, we are controlling the natural resources, especially your food and water, we are taking away your governance, we are taking away your language, you can't practice your religion anymore and by the way, we are taking your children to educate them properly."

I ask that question in workshops that I do across the country for non-native people. The response is, "Well we would fight." and that is what happens in the movies. But then my question is, "Okay, you fought and you lost. What now?" What now? Until 1968, in the United States, an American Indian person living on a reservation could not control their own finances. No bank account, no checkbook, no authority to make decisions about your own money. How many of you would accept that?

So in a nation we see that even today, and I will talk about this more, that a non-Indian that comes onto the reservation and abuses a child physically or sexually cannot be prosecuted by the Indian tribe, and only two in 100 cases will go to federal prosecution. We live in an environment in which safety is not assured. We live in an environment where policing is almost non-existent in some of our communities. So when I talk to our young people about what is driving this high rate of suicide, it is a sense of helplessness, of hopelessness, a lack of self-determination and I will come back to this.

So some of the risk factors for our children are that our children are more likely to have special needs; fetal alcohol spectrum disorder and other learning disabilities. And those children are more vulnerable to child abuse and neglect, and particularly children with special needs and the environment of poverty and the lack of resources to deal with those

issues create a situation in which child neglect of children with special needs is particularly difficult.

There also is a strong relationship between substance misuse, and a prior speaker talked about the mismatch between the need of the addiction and the need of the child. We ask in tribal communities when is substance an issue? Well if the needs of the parent for the substance is greater than the need of the child, you have a problem. Unfortunately, addiction is a disease that will create a circumstance in which the child inevitably will lose out, particularly in an environment where it is hard to get services.

We have family risk factors, social isolation, lack of services, low income and domestic violence. Thirty nine percent of American Indian women report experiencing domestic violence and intimate partner violence. The fabric of an interdependent society and native culture tends to be an interdependent society. We're not the independent, "pull yourself up by your boot straps", individualistic society that is around us. We are an extended family society that relies on one another, but under constant stress, that interdependence begins to break down, compassion fatigue burnout. So we end up with stories today that the grandmother who called CPS and says, "I can't do it anymore," because the kids have abused substances and they are taking advantage in a co-dependent way rather than an interdependent way.

The relationship between domestic violence and child abuse is well known, but we have, because of the way the laws work and because of jurisdictional issues, non-Indian perpetrators who come onto the reservation and abuse women with impunity. Only last year did tribes began to win the right legally to be able to prosecute non-Indian domestic violence offenders, but just because you pass a law, doesn't mean you get to do it. Tribes now have to jump through hoops to be able to exercise that jurisdiction.

So the community risk factors are high concentrations of poverty and low access to services. We have high rates of criminal victimization, as I said, and lack of policing protection. We also have a challenge with regard to the definitions of child abuse and neglect. Federal definitions are different, and actually, the definition in the Indian Child Protection Family Violence Prevention Act is different than the CAPTA, so we have two federal definitions, we have state definitions that are different around the country and we have tribal codes that have their own. So we also know that the definition and the cultural frame for what is neglect is very different.

I recently was in Alaska during the winter working with a tribe and helping them develop their in-home services model. They got word that OCS was on its way flying into a village to pick up five children from the home of grandparents who were out of oil. This is in the Bethel region of western Alaska. The tribe rallied, got a 55-gallon drum loaded onto a sled on the back of a snow machine, and got oil out to that family. But for a barrel of oil those children would have been removed to Anchorage and probably would have never found their way home. Poverty, isolation and access to services are not child neglect. But the response of states has been to find that as a neglectful incident.

A grandmother, and this is a case just recently in the news, who wanted to adopt her grandchild in remote Alaska was passed over for consideration, and this is a remote village and a subsistence culture, because she had guns in her house. And the licensing agent said

that she had to get a gun safe in order to be approved. The only access to her community is by airplane. It kind of set the scale so that she couldn't adopt her grandchildren.

So our recent work with tribal communities is to ask, "What is a safe child?" To have a community process to discuss, to determine and to set standards, our concern is that children in our communities remain safe. I will talk a little bit more about what tribes are doing. The federal data system, NCANDS, does not collect tribal data, as I said, so we estimate that the data in that system represents about 61%, and this is old data now because part of the problem is it is hard to keep track and keep up, but it is hard to tell if that is even a correct number. Some Indian people aren't identified as Indian by caseworkers, and if you are calling things like poverty neglect than is it really neglect?

So these numbers are they over or are they under? We don't know. We do know that in, for example, Alaska, 17% of the population is native, 62% of the children of out-of-home care are native. You can't explain that by anything but bias. The abuse rate is actually lower. Numbers are similar in South Dakota, but in Multnomah County, Oregon, where Portland is, the placement rate for native children is 28 times higher. Twenty eight times that of white children. So we know the American Indian children are way over-represented. So we want to know what the problem is. The National Incidence Study is extremely important to us. We know that our American Indian reports are about the same numbers for the dominant population, but we are two times more likely to be investigated. Those that are investigated are twice as likely to be substantiated and if substance abuse is an issue, that jumps to eight times for an American Indian family.

You can read in the testimony the other prevalent issues. I do want to just close with that historic frame I gave you. The Dawes Act, also called the Allotment Act, gave every Indian person a plot of land because they wanted to end tribal ownership of the land. Which means we have checker boarded reservations and if child abuse happens on the reservation, you have to know whose land it happened on, whether the child was Indian or non-Indian, an Indian of that tribe or another tribe, whether the perpetrator was Indian or non-Indian, and whether they were an Indian at that time.

Depending on those factors, you know who to call and you know where to prosecute. It might be tribal court, it might be State court, it might be federal court. The only way to cope with that environment is to create local teams, to have intergovernmental agreements, to sit down with one another's State, county and tribe, working out local protocols on investigating child abuse claims and making agreements that whoever shows up first will partner with whoever is determined to have jurisdiction.

As I said, in the northwest, of 100 child sexual abuse cases that are reported, two will end up with the perpetrator being prosecuted, because only 39% of cases are even accepted by the federal government for investigation. By the time an FBI agent gets out to a reservation there is no evidence.

The funding streams are inadequate. Tribes have access to IV-B, Part 1, but most tribes get less than \$10,000. Some tribes have access to IV-B, Part 2. We don't have any access to title XX and the only access we have to CAPTA is discretionary funds. So only about \$300,000...I know CAPTA is very small, and as a child advocate I think that's appalling, but you would expect there to be, for four percent of the population we get less than 1/10th of one percent going to Indian Country. We have a few demonstration projects and the Indian Child

Protection Family Violence Prevention Act was passed in 1991, authorized at \$65 million. One year and only \$5 million was appropriated. One year. We have not had an appropriation for that law since 1993; I think it was \$5 million was appropriated. How can you do anything in Indian Country? You know, it is one thing to pass a law, something else to make it possible.

The bright spot on the horizon is the Affordable Care Act, and the Home Visiting legislation, MIECHV, was successful in getting tribal language into that law, and now I believe it's about \$50 million going to tribes for home visiting for child abuse prevention, the first cohort in 2012.

We are working with tribes to help try and develop in-home services systems of care. We are using the principals of the Touchstones of Hope and a set of principals developed by international indigenous groups to reclaim child welfare and decolonize the child welfare system. It is based on five principals of self-determination, holistic approach to services, central use of culture and language, structural interventions to deal with issues of poverty and untreated trauma, and non-discrimination. It is using the work of racial healing and race equity to drive this work.

We are training to build capacity. We are training communities to use child protection teams, and we now have villages in Alaska that haven't had a placement outside of their village in five years, because they are using a community-based approach. Services for families do not work to protect children unless you can put eyes and ears on the child. There is no way a State entity can take custody of an Indian child on the reservation or rural Alaska and have as many eyes and ears as we can have in our community, but we need the resources to tie together the school, the clinic, the housing department, WIC and child welfare, coordinated and community-driven.

Recently, on the island of St. Paul, out in the Bearing Sea, I had seven youths, and this is a community of 450 people, and yet our planning session on an in-home services system of care model, participation by seven youths in the community. By the time we left those seven youths had planned a softball tournament to support the young dads in the community and give them information about being fathers. We are solving our own problems but we need help. And so my opportunity to speak with you today is to hope that you can influence this federal policy that has created layers of governmental dysfunction that actually keeps perpetrating harm rather than offering solution. Access to CAPTA funds, funding of the Indian Child Protection Family Violence Prevention Act, these are essential if we are going to be able to protect our children.

But we are not waiting, we are out there organizing. We are getting grandmas, aunts, uncles and elders. In the Bethel region, a gentleman whose name is Andrew Beaver formed a child protection team in his community. They don't wait for bruises, they don't wait for abandonment. When they hear that there has been a domestic dispute, or where there has a party the child protection team meets, they select two individuals, and they go knock on the person's door. When the family opens the door the first question is, "Is everybody okay? We've heard there was a problem. We want to make sure everyone is okay, and we want to come in and talk with you because in our village we have standards of how children should be treated, and this is not okay. We want you to know we are watching and that we value everybody and we want to know you are okay." So I hope that you will help us ask that question in Indian Country, "Is everybody okay?"

Thank you.

COMMISSIONER MARTIN: Thank you so very much, sir. We really do appreciate your testimony. Are there any questions from Commissioners? Yes, Commissioner Petit.

COMMISSIONER PETIT: Terry, hello. It has been a while. Thank you for that presentation and that illuminating historical perspective. It would be great if this Commission were able to rewrite some of that history. But we are charged with the immediate issue of addressing the question of child fatalities. Do you have information on that? Is there a place that we can go to and see what the number of children are in Indian Country, either on reservations or off reservations that have died at the hands of family members? Is that information available?

TERRY CROSS: What is available in my written testimony is you will find that the rate is exactly the same as the mainstream population. We don't know how good that number is, and it is not even clear how child fatalities are tracked in Indian Country. There is just no mechanism to do that. So one of the major issues is being able to have the information about it.

COMMISSIONER PETIT: So if the rate is about the same, and we look at the measurement and it's per 100,000 children.

TERRY CROSS: It's about 2.2, something like that.

COMMISSIONER PETIT: Yes. So nationally, is that 100 children? Is it 500 children? If you just apply that proportionately, do you know? Does somebody keep that?

TERRY CROSS: Yes, it is a handful of children. It's not...

COMMISSIONER PETIT: The other thing, if I could ask...were you finished?

TERRY CROSS: No, I was going to say that in our communities we have the same difficulty, I believe, as the mainstream society of determining what types of child deaths are related to child maltreatment and what is a tragic accident versus what is willful withholding of care. So for example, we have the highest rate of child electrocutions of any ethnic group in the country, but it is because of unsafe wiring and poor housing, and if you couple that with a situation where you may have substance abuse and lack of attention and children unrestrained in car seats, for example, and in many places people don't have access to car seats. So it's a very, very difficult number to get.

COMMISSIONER PETIT: If I may just complete this, you mentioned local teams, which I think are very promising, and you described some specific things that happened within those teams, which I thought sounded very good. Are they actually in place now, and how much in place are they?

TERRY CROSS: Not nearly enough. It is just that there are an awful lot of what are called either child protection teams or multidisciplinary teams that aren't what you would understand from the literature of what those teams are. Literally, they are people gathered in communities trying to deal with an issue that they are concerned about and would have knowledge about child abuse and neglect but working and doing more prevention and that sort of thing. In terms of the numbers, there are supposed to be, according to the Indian Child

Abuse Prevention and the Indian Child Protection, one in every community run by the Bureau of Indian Affairs. They have never implemented one.

COMMISSIONER PETIT: Do they also occur off reservation and are there non-Indians that participate in the process?

TERRY CROSS: Yes. Urban programs, it varies across the country, but there are 32 American Indian Centers, or approximately that provide some kind of family support, and many of them partner with the city, county and the state. So for example, Native American Youth and Family Center in Portland is a contract with the state of Oregon to provide in-home services and do a lot of early childhood support and family intervention.

COMMISSIONER MARTIN: Mr. Cross, we have a question from Commissioner Sanders, who is on the phone.

CHAIRMAN SANDERS: Thank you for the great presentation. To follow up to Commissioner Petit's question about the community groups that you talked about, can you say a little about federal policy and state policy that helps to clarify some of the jurisdiction issues that you talked about, particularly in investigation? Who is it that could potentially oversee the creation of the teams that you described?

TERRY CROSS: Well, the Indian Child Welfare Act was passed in 1978 and does two very important things; it sets up criteria that states have to follow when they take an Indian child into custody and it empowered tribes to run their own child welfare programs. A less non-provision of the act is that it authorized states and tribes to enter into agreements with one another, and that is the mechanism that has been used to create joint investigative approaches and to set up joint teams. Where we see the most success is where tribes and states cooperate with one another. As many people know, there has been a lot of implementation problems with the Indian Child Welfare Act, but not in places where the local government or child welfare department has formed intergovernmental agreements with local tribes, and that implementation and compliance is actually quite high when those agreements are in place.

So I think the mechanism already exists. Peeling back the layers of the onion around the jurisdictional issues is very difficult, but a piece of legislation that is desperately needed would be an enactment of legislation similar to the provisions of BOWA that opened tribes' capabilities to prosecute non-Indians in child abuse cases.

COMMISSIONER MARTIN: Thank you, and Commissioner Horn?

CHAIRMAN SANDERS: Can I just ask a quick follow-up to that? I'm sorry. So thanks for the answer to that. What I am less clear about in the tribal-state agreement, and particularly looking at the role of investigation, is I don't believe most of those agreements actually include the federal role as it relates to potential investigations on tribes. So do you see that as part of the agreements that have been put in place or is that more voluntary?

TERRY CROSS: Well it has been much more problematic in the non-280 states, and I mentioned 280 briefly, but in the 1950s, there was a major assimilations move with several pieces of legislation aimed at removing jurisdiction from tribes, terminating tribes from existence. Public Law 280 was part of that. It was an elective law that a state legislature

could vote to assume civil jurisdiction on a reservation. The Supreme Court later ruled that was a wrongful taking, but it didn't restore it, it said a tribe could retrocede and pull that back. So you have eleven states that have at least concurrent jurisdiction over child welfare and a couple of states that claim they have full jurisdiction. There is no jurisdiction of tribes in Alaska and California problematic in that way, but their own Supreme Courts have since ruled differently. Where there is this relationship between states and tribes already, if you have concurrent jurisdiction, it is a race to the courthouse, basically. And so in those jurisdictions you tend to see the agreements between the tribe and the state without a federal role. Another layer of this is since self-determination, many tribes have removed themselves largely from federal oversight through this self-governance compacting.

So it is basically tribes can petition the federal government to take all of the resources that would come to them through the BIA and the Indian Health Service and receive that money through a block grant and determine their way of spending the money. It's called tribal self-governance, and there are a growing number of self-governance tribes, and I use the term "decolonization" and it really is a process of reclaiming self-governance and determination of how one's resources are going to be applied in the community. The non-280 tribes are a minority of the tribes in the country at this point. 565 tribes and probably over 400 of them are in 280 states. And again, these questions are hard to answer because of all of these layers. Oklahoma is different than every other state, New York is different than any other state, Alaska, and California both different from any other state. So states that have large land-based tribes, like the Dakotas, they have their own issues, and even in some treaties, jurisdictional issues were spelled out in the treaties, so you can even have a community, one tribe, where the jurisdictional issues are different.

COMMISSIONER MARTIN: Thank you very much. Commissioner Horn?

COMMISSIONER HORN: Thank you for your testimony. I must confess I was not aware that NCANDS did not include Native Americans who are served by tribal child welfare systems. Why? I mean, why not?

TERRY CROSS: Funding streams and legislation. So tribes don't receive CAPTA dollars. Of course, the way the federal policy works is through the powers of the purse strings and states report because you don't get money if you don't report. So there has never been a mechanism and the change until the 1970s. Child welfare services on reservations were either provided by the federal government through the BIA or through a state, if you were in a 280 state, and so you would get the information from the 280 state. Except that even in 280 states, Oregon for example, the Warm Springs Tribe, the largest tribe in the state, was exempt from Public Law 280 so you wouldn't get any data from Warm Springs. Then Umatilla retroceded from 280, so you wouldn't get any data from Umatilla and so if you don't have a scorecard of who is who and what is what you don't know who is doing what. Now the BIA gathers data, but the number of places where BIA social workers are providing child welfare services is very small now because of self-determination and self-governance, and they have never reported data to the NCANDS database.

COMMISSIONER HORN: But if the money were there to support the reporting mechanism, given the sovereign status that tribes have, there wouldn't be an issue from the tribe's point of view.

TERRY CROSS: Exactly. And actually, tribes have been advocating for that for a couple of decades. In the early 2000s, NICWA had a grant from the Office of Child Abuse and Neglect to do a study on how tribal data could be reported to the NCANDS database, and we provided HHS with a roadmap of how that could be done, and testimony from tribes as to their willingness to participate, and nothing was ever done with that.

COMMISSIONER HORN: When was that?

TERRY CROSS: I think it was 2005.

COMMISSIONER MARTIN: Thank you. Commissioner Rubin?

COMMISSIONER RUBIN: Thank you. That was a really terrific presentation and really illuminating in your testimony and your written testimony is helpful as well. I'll start off by saying that one thing we have heard really across the country is that the over-specification of federal funding streams for child welfare inhibits local flexibility for locally-driven solutions, and I think one thing I took away, particularly from your written testimony and what you said today, is that this is particularly an issue in Indian Country for a variety of reasons.

My question though is a couple of years back I had the opportunity to visit Gallup, New Mexico, and Window Rock, and spend a little time with some of the Navajo, and some of the Navajo child welfare workers, actually, and talking about sort of what they perceive as barriers. And I had a very interesting conversation with a Navajo child welfare worker who made the comment that one of the challenges that he had working on the reservation was that historical context, if you will, in some ways raised the threshold by which, in some ways, there was some recalcitrance within the tribe to respond to some of the child welfare issues, and that he was frustrated because there was some guardedness about that historical context, and so therefore the imminent risk of harm to a child almost had to have an elevated threshold before responding, and you might look at that imminent risk of the child or also even the prosecution of folks in the tribe who were perpetrators, right?

TERRY CROSS: Um hm.

COMMISSIONER RUBIN: I'm just wondering what kind of promising approaches have you seen around sort of balancing that issue of the historical context with the eminent harm to the child?

TERRY CROSS: Well I mentioned these conversations that we have in the community around, "What is a safe child?" and that is so essential. To begin to have that conversation, as tribes have assumed jurisdiction and developed their child welfare programs they have made a huge change. Right after graduate school I went back to my own tribe to work and I became aware of children who I knew were being abused but the county wouldn't come onto the reservation.

We didn't have a child welfare program on the reservation. If it was politically sensitive, the tribal police wouldn't investigate. Today that has changed dramatically. With self-determination, with strengthening of court systems with the professionalization of both the child welfare and the policing in the courts it is a very different look. And it has been, historically, too easy for people to look the other direction if it was their relative. And so you are right, this is a sensitive issue, but I know, because this is my 42nd year, if things get as

much better in the next 40 years as they in the last we'll be in pretty good shape. But it takes time and you don't just start. And as a child advocate, I have to convince tribal leaders that children are as important as timber or fish and other resources. So I think what you are hearing from a child welfare worker and Navajo Nation is the same concern that you hear from a child welfare worker in a county system where more resources are needed and a higher standard of care is needed.

COMMISSIONER MARTIN: Commissioner Covington?

COMMISSIONER COVINGTON: Yes, I really thank you for your testimony and also for the written testimony. I'm sitting here and want to read it all. So thank you so much. It is really detailed and wonderful. I didn't get the piece about was it a fund that was appropriated and never appropriately appropriated?

TERRY CROSS: No, it was the Indian Child Protection Family Violence Prevention Act.

COMMISSIONER COVINGTON: Okay. So tell me some more about that and where that is at.

TERRY CROSS: In the late '80s, when internet was first coming into being, it was discovered there was a network of pedophiles who were posting that if you worked on an Indian reservation you didn't have to worry about getting prosecuted for violating children. And an Indian Affairs employee, at a school in New Mexico, sexually abused over 100 children.

The BIA's solution was to put a window in his door in the classroom. Congress' response was to pass a law that said you had to do mandatory reporting and that there should be child protection teams everywhere in the country and that there should be resource centers available to tribes to deal with child abuse and neglect, authorized at \$65 million.

The mandatory reporting was put into place, BIA and IHS, Indian Health Services, never fully implemented the child protection team because no money was appropriated and the Child Abuse Resource Centers were never put in place because Congress never appropriated funding for them. So a knee-jerk reaction to a serious problem of pedophiles coming onto the reservation resulted in no infrastructure.

COMMISSIONER MARTIN: Thank you. Commissioner Bevan?

COMMISSIONER BEVAN: Hi Terry. We have been at this a long time. From your data, there are several factors that are a link to child fatalities. I mean, you have double the poverty rate in Indian Country, substance abuse is very high, you have double the unemployment, you have double the number of single parents, and then you mentioned my real concern, which is children with disabilities. What I have been trying to untangle throughout these whole Commission hearings is how do we know that some of these children with disabilities are not dying from child abuse and neglect fatalities and that they should be counted as a child abuse and neglect fatality rather than dying from whatever disability that they have. So what is the entity in Indian Country that investigates the child fatalities, and how do they count it?

TERRY CROSS: There is no entity. There is no entity at this point. We don't have the same kind of infrastructure that a state would have investigating it. Now I also want to reassure you in another way that culturally children with disabilities are held in high esteem. One of the reasons you see the numbers of neglect as extremely high but the abuse is lower than main

stream society is the spiritual teachings of our tribes say that children are sacred beings and that they need to be treated in a particular way, that they had come to this world recently from the Creator and they know what it is like to be with the Creator. It's wonderful. It is a tremendous environment. And in order to make them want to stay in this world you have to treat them well. You have to sing to them, and to hold them, you have to talk to them. You have to make their spirit want to stay here. Children are sacred gifts of the Creator and if they are mistreated, they will be taken back by the Creator.

So this fabric of cultural beliefs that have sustained throughout this period of colonialism...amazing that we have been able to hold on to that despite the assaults, keeps the physical abuse low. And children with disabilities, if you go to a tribal community and gathering you will see people attending a child with disabilities in ways that you just wouldn't see in mainstream society. Nobody would think of leaving that child to be left out. They are brought into the circle. So while I am sure that the high rates of neglect are endangered children, I worry about the child in the substance abusing family who needs medical attention and doesn't get it because the needs of the substance. But that's not unlike any other culture. But the mitigating factors of the cultural beliefs are there that help protect them.

COMMISSIONER MARTIN: Thank you so very much.

COMMISSIONER BEVAN: Thank you, Terry. I feel a little reassured, the way you describe the child and the culture.

TERRY CROSS: Thank you.

COMMISSIONER MARTIN: Thank you so very much, Mr. Cross, for your testimony. I believe quite a few of the Commissioners still have questions so I anticipate that you will be bothered by our Commission soon. But thank you so much for testimony this morning.

TERRY CROSS: Thank you for the privilege.

COMMISSIONER MARTIN: Ladies and gentlemen, we are running a few minutes behind, but I would like to invite our next speaker, Ms. Emily Douglas, Dr. Douglas, to come forth. Dr. Douglas is going to talk with us about and examine the systematic properties of the child welfare system that may enhance the risk once the family comes into contact with the child welfare system. Welcome so very much. Thank you.

DR. DOUGLAS: Thank you. I would like to thank the Commission for inviting me here today to give testimony about the work that I have done, about the intersection of the child welfare system and fatal child maltreatment.

Here is an overview of what I'm going to do today. I'm going to start with a little bit around definition and prevalent traits, talk about characteristics and risk factors for fatal maltreatment, and the reason I am setting the stage for that is because part of the work I have done is to ask workers about their level of knowledge for risk factors. So I first just want to go over what those risk factors are and then get down into the meat of the work that I have done about worker's knowledge and understanding of risk factors, then talk about workers who have experienced a child dying on their caseload, then explore how it is that workers may miss warning signs that then lead to a child dying, and then provide conclusion and recommendations. So I am just giving you a preview up front about what some of my

recommendations are going to be around increasing training for child welfare professionals about risk factors for fatal child maltreatment, to integrate assessment for child welfare workers or among child welfare workers for fatal child maltreatment across the board, everywhere from screeners all the way up to supervisors and managers, to initiate conversations about simultaneously assessing for both the risks and strengths in a family, and to increase research funding to better understand child welfare practice.

So whenever I talk about fatal child maltreatment I always start with what is the definition? What is it that we are talking about? And this is the definition that is used by NCANDS, and in the work that I have done with child welfare workers this is the definition that I provide for them too so that everybody is clear about what we are talking about, and then there are some of the acronyms that I will use throughout the talk today.

This is just a chart showing the prevalent traits. On the right-hand side, on the "XX" at the bottom, we have the years and on the right-hand side, we have the number of children who have died. On the left-hand side, we have the rate of child deaths per 100,000 live children, and I am sure you guys have seen this at some point already in the testimonies that you have received.

This is from NCANDS as well, and this consistently shows over time that children are more likely to die from physical neglect than from abuse, and if you add in medical neglect then it is even higher. This, of course, comes to more than 100% because children don't always die from one form of maltreatment.

Some causes of death by abuse include blunt force trauma, immersion drowning, suffocations, stabbing or shooting from a caregiver, poisoning or immersion burns. And then death by different types of neglect, including supervisory neglect, which is the most common form of neglect that leads to fatalities; drownings, animal bites, ingesting poisoning, accidental firearm discharge, house fires. And then physical neglect; malnutrition, failure to thrive, starvation, animal bites, and there is some overlap here. And then medical neglect where parents refuse to seek treatment for a variety of reasons or they refuse to comply with the treatment that has been offered.

So I would like to do a brief review from the literature about what are the risk factors for fatal child abuse and neglect. I am going to go over parent and caregiver characteristics, the parent/child relationship, and the environmental and situational factors. These are the characteristics that I have asked workers to have had as well.

Children who die are very young. About half of children who die are under the age of one, and about close to three-quarters are under the age of three. Boys are slightly more likely to be victims of fatal child maltreatment, and this comes from the NCANDS data. This ratio is a little bit higher than I have seen before, usually I see closer to a 45/55 split.

We know that African-Americans are over-represented as compared to how they exist in the population at large in terms of fatal child maltreatment victims. We know that children are very young, we know that boys are slightly more likely to die, and we also know that caregivers who describe their children as being difficult in some way, that they have a behavioral problem are more likely to die as a result of abuse or neglect, and that is the caregiver's assessment. Whether or not these children are actually more difficult we don't know. Also, children who have had a history of out-of-home placement.

The relationship between the perpetrator and the victims. Moms are more likely to be responsible for children's deaths. That is probably due to the fact that children are more likely to die as a result of neglect, and also that moms do more care giving still at this point in our society.

Other characteristics of caregivers: parents tend to be young and are in young adulthood; so under the age of 30. They often have had a major life event in the last 12 months of their lives, so losing a child, or moving, divorce, adding a new family member, and et cetera. They are often unemployed with a history of violence in the family or in the household, and there can be a history of mental health concerns and substance abuse concerns.

The parent/child relationship is an area, which has not received a lot of attention because it's not always captured in the data sources that we have. But parents often describe their child as not being respectful of them, and that's even true of infants. Parents will say that the child engages in provoking behaviors, the child won't finish his or her meal, "I have a busy schedule," "I've made with the child," and this could be said about an infant, about a toddler. These are parents who often have low levels of parenting skills, and these are often parents who have low levels of knowledge concerning basic child development and developmental norms.

The environmental and situational factors that can be related to a child dying of maltreatment include a recent change in household composition; somebody moving into the family, somebody leaving the family, having non-family members present in the household, and having unemployment be present in the household that is above and beyond just the caregiver. Families that are especially mobile, that move a lot, that is a risk factor for a child dying of abuse and neglect, and 30% to 50% of children who die, their families were known to the child welfare system before the child died.

So in this next area, I would like to move on and talk to you about the work that I have done and some research that I have done with child welfare workers across the country. And this was a study that I conducted in 2010 and 2011, and the purpose of this study was to explore workers' understandings of risk factors for fatal child maltreatment, to learn new information about services received before the fatality, to describe the characteristics of children and their families who are known the child welfare system and who die, and to explore the experiences of child welfare workers in the aftermath.

I conducted the study in the 2010/2011 year, and this was an online survey. This is a convenient sample. I had a sample of about 450 child welfare workers, front line and supervisors. I recruited them through a variety of online methods. The Child Maltreatment Research Listserve, which I am sure many of you are familiar with. Sometimes the research offices in each state would help to recruit workers when they found out that the study was being conducted, and I also made direct appeals to child welfare agencies.

I am going to present to you today about 425 participants, 129 of those experienced child fatalities on their caseload. Ninety percent of those who participated in the study were female and about half of them had a Master's degree. Their fields of education, if you add in social work and human services, about close to two-thirds of them had a degree in that area. Their average age was 41, you can see their racial breakdown here, and there is racial

diversity but not a lot, and it was throughout the country, the largest proportion being from the south, and then the next area being the west.

This is a convenience sample, and this may have drawn special interest from individuals who had experienced a fatality, or who have an interest in it. It may have been in their office, because we know that when a child dies it has not only significant implications just for that worker, but for the entire office and obviously for the state.

All right, so about three-fourths of the workers who completed the survey indicated that they had received some type of training on child maltreatment fatalities. Now these are the questions that I asked them, and these are statements that I provided and they indicated the extent to which they agreed or disagreed with them, and you will see that some of these statements are accurate and some of these statements are false. So for example, a false one is, "Most parents who kill their children do not have a mental health problem," or "Children are usually killed by physical abuse as opposed to neglect." And one that would be accurate is, "Parents who kill their children probably saw their child as difficult or ill-behaved in general."

This next slide is just those same statements again, and then with the percent who disagreed with these statements. So for example, "Moms are most likely to be responsible for their children's death." That is an accurate statement, and only 20% of the workers agreed with that statement. "Most parents who kill their children do not have a mental health problem." That is a false statement and only close to 20% agreed. "Most children are killed by physical abuse as opposed to another type of maltreatment." That is a false statement and 58% of them agreed with that statement. "Children are most likely to be killed by a non-family member." That is a false statement and nearly two-thirds of them agreed with that.

So we see some better numbers through the other statements, with perhaps the exception of families that move a lot are more likely to suffer. Also, having non-family members living in their homes.

There are some fairly significant gaps in knowledge here. At the same time, I asked workers about some other types of experiences and their concerns around fatalities. Over a quarter of workers said they had had a parent on their caseload tell them that they might kill their child. Almost three-quarters said that they worried that a child in their caseload will die. Almost all workers, when they are working with a family they look for signs that they think will lead to a fatality. Workers feel relatively confident in their knowledge that they have. Only 14% say they are not sure what the risk factors are, but most of them would still like more training.

The next question becomes where is it that workers do learn about risk factors for fatalities? So I did some work with some colleagues and we first started by looking just at textbooks that had to do with child abuse, child development, the kind of textbooks that students major in Social Sciences but more likely also social work would be likely to read.

We looked for content around fatal child maltreatment; for definitions and cause of death. You can see this is the percent to textbooks that have content around this, but what we see mostly are just a definition of fatal child maltreatment. Causes of death, which also might be related to why workers are more likely to think that children die as a result of physical abuse

also gets more media attention. So workers aren't getting a lot of information from textbooks, we know that.

Then some colleagues and I also examined the pre-service child welfare training curriculum. So this is the training curriculum for new child welfare workers. And we looked at the training curriculum from 20 states, so those are the states that provided with their information. Only one state had a section on fatal child maltreatment, and that was Florida. In Florida that state did not provide an evidence-based review of risk factors, instead they described the characteristics of the children in their state who died, which certainly may be relevant, but I'm not sure that it is a conversation that is being had around what are risk factors. Now of course, this is what is just in the formal training, so there may be informal conversations that are going on during the training that include information on fatalities. But in terms of what is formally built into the structure of pre-service child welfare training curriculum there does not appear to be a whole lot of information.

So now I would like to move on to the next part of my talk, which focuses on workers who have experienced a fatality on their caseload.

If we say 30% to 50% of children who die from maltreatment were known to their child welfare system, and we take the number of kids who died in the past year or average it out, and then we take 30% to 50% of those and say, "Well they all would have had a worker and they all would have had a supervisor," to try to figure out how many workers actually have a child die on their caseload. So I estimate that between 10/50, 10/62 and close to 1,400+ workers experience the death of a child on their caseload, which is about three-to-four percent of the child welfare workforce. But certainly, as I mentioned already, when a child dies it has reverberations throughout an agency. So it is not just those workers who are affected.

But the real question is what is it that we know about these workers? And in fact, we don't really know a whole lot about who these workers are. We have a lot of headlines from the media. So for example, here is one, "Race to the bottom. Untrained social workers; overworked and more dead and suffering children in Indiana." I've seen headlines that say, "The Department of Human Sacrifice." None of this does well to help child welfare professionals in the work that they are doing. This is from the advocacy organization, the National Coalition for Child Protection Reform. "In most states a Bachelor's degree in any subject is all that is required for becoming a Child Protective worker. After hiring, training it generally ranges from minimal to none. Turnover on the job is constant. The worker who goes into troubled families is likely to have little experience. Caseloads are enormous, often double, triple or more than the average called for by CWLA."

"Social workers are untrained for violent parents," that is from The Guardian. This came from the Washington Children's Administration, a report that was done in the wake of a child fatality case. "The committee felt assigning high-risk investigations to newly hired and inexperienced CPS social workers may present risk issues for the Children's Administration. And a top priority was to improve training for child welfare supervisors so they can help inexperienced caseworkers who are stymied in investigating abusive families."

So there really is this sense that children are dying because they are being assigned to untrained, inexperienced, uneducated young social workers or child welfare workers, but we

don't really know if that is the case. So I just have this slide here because now I'm just going to talk to you about those workers in my study who experienced a death in their caseload.

Their demographics don't really look that different, for the most part. And when they experience the fatality...so this really could have been at any time, and I do like to disclose that three percent of them had a fatality that occurred a very long time ago, but 65% plus 17% experienced a fatality within the last 10 or 11 years, and almost 20% had experienced it in the last year that they took the survey.

This slide shows who are the workers experiencing a fatality on their caseload. In the column on the left, we have the characteristics. The next column over we have the total for all child welfare workers who experience a fatality, and then the next two columns break out the front line workers and then the supervisors.

At the time that the fatality occurred the number of cases on a caseload, the median was 25, and that was 20 for a front line worker and 90 for a supervisor. And that doesn't differ too drastically from CWLA recommendations, which are 17 for a front line worker and 85 for a supervisor. The number of months that this family had been on the worker's caseload was about two. The number of years that they had worked in the child welfare profession overall was six, but four for a front line worker, and 13 for a supervisor. And at the time that the child died the age of the worker at the time of the child's death overall was about 38 and about 35 for a front line worker and about 41 for a supervisor.

Their education levels, is what follows next on this slide. They are educated. About half of them have a Master's degree and they appear to be educated in the appropriate fields. So the sense that it is child welfare workers who have an Associate's degree in Art History who are performing our child welfare work and are causing fatalities in not recognizing them...well, at least I'm not sure that there is a whole lot of evidence to support that kind of notion.

On average, families had been involved with the child welfare system for about 10 months before they died. Workers had seen the child about, the median was about one week prior to the child's death, and with the federal mandate of seeing the child every four weeks, 85% had seen the child within the past four weeks.

I asked them about how they felt about the case before the child died. Eighty four percent of them said they felt confident handling the case. Eighty two percent said that they had conducted a full risk assessment on the family before the child died. Over three-quarters said that they felt that they had received appropriate guidance in how to handle the case before the child died. Two-thirds said they felt the family was being closely monitored. Only about a quarter felt that the death was unavoidable, and I don't have more information about that. It was an interesting area that we need to tease out.

In general, these are workers who didn't say that they wanted to be doing something differently. Only about 10% of them said that they wanted to be pursuing a different avenue, but that they weren't receiving the proper kinds of support from their colleagues or that the state wouldn't allow it, agency policy, state policy, and et cetera.

Of course, some of this may be self-protection, sort of looking back. Nobody wants to believe that they are responsible for a child's death. But this is how they are assessing what was going on with the family before the child died, retrospectively, of course.

So last, I would, before we move into conclusions, like to talk about how it is that workers may miss some of the warning signs. And before I do that, I would like to read to you a quote from a worker who participated in my study. It is a little long, but it is quite important, I believe.

She wrote, "The blame for a child death usually lands on the front line worker. We cannot live with the families we work with. While a good service worker can prevent some maltreatment, it is impossible to prevent all maltreatment. In some situations workers do not have the evidence needed to legally mandate a family into services, which might prevent the maltreatment. As a worker, I am extremely stressed by my caseload and frequently worry that a child will die. I work weekends and sometimes until 8:00 or 9:00 PM to keep up with the work, but if one child dies I will never feel that I did enough. Most child welfare workers truly care about the families on their caseloads. But preventing maltreatment while keeping up with 20 to 30 investigations is impossible. We are fighting a losing battle. My entire academic experience as a professional social worker has prepared me for this job, and I am still overwhelmed by the massive responsibility."

So the truth is there has been no research to be able to link actual practice behaviors from child welfare professionals to children's deaths. So at this point all we can do is really speculate about what might be leading to this and draw a little bit on the field and the literature about child welfare practice.

The social work profession is based on finding strengths as a point of entry for working with the clients. Finding strengths is a necessary and essential component of child welfare practice. This can be a basis of building a strong foundation for a healthy rapport with families and with any luck it can help to build a stronger and a safer family for that child. A strengths-based practice is primarily focused on identifying client strengths and resources and mobilizing resources that directly or indirectly improve a problem situation.

That said, strengths do not make the presence of risks to children disappear. Indeed, other than paperwork and dealing with families that usually do not want you in their lives, one of the most challenging part of child welfare practice is balancing these two ends of the social worker and child welfare practice, the strengths and risks, and knowing and understanding that families can have both of these present at the same time, and that having a strength does not make a risk disappear. So colleagues and I recently discovered this. I teach Master of Social Works students, and we have our students in the field the way all social work programs do.

A colleague and I recently were discussing a situation that occurred in an elementary school, so in truth it was not within the child welfare profession, but it was related to a child experiencing abuse. And a Masters of Social Work student was completing an internship there and a child came to the nurse's office stating that his arm hurt where his father had hit him the night before. It was sore to the touch. This constitutes a pretty high-risk situation for this child, and in this situation the child has become the help-seeker. So the social worker at the school, not the intern, knew that this family was open to DCF and knew that the father had asked for voluntary services. Mom had left this family and dad was overwhelmed with five kids in the family. So the social worker called dad to talk about the situation and the father disclosed, "Yes, I did hit my son. I lost it, and I hit my son last night," and the social worker viewed this as a strength, which indeed it is, it is a strength.

As a result of this she decided not to call child welfare services and the student wrote in her field journal, "This was a great learning opportunity because I learned the difference between a risk factor and a strength," and, in fact, both of them are present in this family and this child is in a very dangerous situation. This child is now going to go home to a father, a parent who knows that he sought help, that the social worker called him. The child is now in the position of being the help-seeker in this family, and this child really needs protection. So this family is open to DCF and dad is still hitting this child enough that it hurts the next day. So, in fact, balancing these strengths and risks is really something that is in need of further attention.

But there has been very little research on how a strengths-based approach is integrated into child welfare practice. At this point, we only have anecdotal evidence about a potential conflict that the child welfare profession may be experiencing with regard to this approach. The term is used so frequently throughout social service practice that one has to question if workers understand some of the most basic components of the strengths approach. There are important questions to ask in this regard. At the most basic level, do we know what a strength is? Do workers know what a strength is? Living in a nice community, having a beautiful home, these are nice things, but they are not strengths and they do not offer the potential to act in a protective capacity for those children.

I have a colleague who is a child welfare supervisor and I was having conversations with her and learned that she and her colleagues call this strength-based confusion. And things such as that the family has nice curtains appear in workers' case notes. So I learned last weekend there is a new program housed at Temple University at Harrisburg that offers a family support worker special credentials, like you can get a certification, and using a strength-based approach in their social service practice. In my initial review of the curriculum, there is a lot of discussion about strengths, but I didn't see anything that defined what is a strength or that could be identified in a family. And what this does is leave workers to decide what are strengths on their own.

So in the essence of time, what I would like to move on to, and you are going to be hearing more today later on about risk assessment tools. And all agencies are using risk assessment tools. But risk assessment tools do leave workers open to some interpretation. Risk assessment tools can be overruled. There is an opportunity to either bump up the risk, because I think maybe these families deserve service, or to lower the risk because the family doesn't really seem to be at risk.

I am going to move on to my conclusions. Workers are deeply concerned about child maltreatment fatalities. We are not preparing workers especially well for seeing and understanding risks. There is a lack of knowledge of risk factors. Workers who experience a fatal child maltreatment on their caseload are not young, they are not unprepared, and they are not inexperienced.

Workers may not be assessing for risk over the life of a case, and instead just at important points, such as investigation, or assessment, or before family reunification. Workers' own attitudes influence their evaluation of risk. Workers who believe more strongly in risk are more likely to see risk and are more likely to remove a child. Workers need to be trained in risk factors for fatalities. There needs to be a priority across the board, from the legislature all the way down to the supervisor. Discussions around risk factors for fatalities need to be

integrated into daily, routine case work, and we need to open conversations about what constitutes a strength, and how risks and strengths cannot cancel and do not cancel each other out.

So I recommend that we have an increased training for child welfare professionals about risk factors for fatal child maltreatment. This is something that could be integrated into, for example, the work that CWLA conducts with regard to issue guidelines around standards for the profession. That we integrate assessment for fatal child maltreatment across the board from screeners, to supervisors, to managers, almost having a fatality lens when we look at cases. To initiate conversations about simultaneously assessing for strengths and risks in a family, and to increase research funding to better understand child welfare practice, knowledge of risk factors, relationship to death and serious injuries, and how strengths and risks are understood and balanced.

COMMISSIONER MARTIN: Thank you so very much, Dr. Douglas. I believe Commissioner Horn has a question for you.

COMMISSIONER HORN: Yes. We have been at this for about eight months, and we have seen some terrific presentations. That was a terrific presentation.

DR. DOUGLAS: Thank you very much.

COMMISSIONER HORN: It is extremely helpful and right to the point of this Commission's work. I want to get to this question about risk assessment tools. Unfortunately, we ran out of time, so I'm going to give you more time by asking you a question. How much confidence should we have in risk assessment tools?

DR. DOUGLAS: Well, I can go back a little bit over what I was going to say about risk assessment tools, and I also want to preface this by saying I am not an expert in risk assessment tools, and you are going to be hearing from somebody else later today whose expertise really is around risk assessments. It is an area that I have been paying more and more attention to as I have spent more time with workers and really talked with colleagues around this.

There are primarily two types of risk assessment tools. We have the consensus-based, which is based on theory, research and practitioner opinion, and these often don't differentiate between abuse or neglect, which can be problematic because those are really two different things, and two different sets of risk factors that are related to those outcomes. There is also a lot of great variation between these tools.

Then you have actuarial risk assessment tools, which are statistically derived, they are numerically scored, they come up with a number and they feel more objective. They often do differentiate between abuse and neglect. And I'm not sure that the concern is so much around risk assessment tools, to be honest with you. I think it has to do with our interpretation of risk assessment tools and how risk assessment tools are integrated into child welfare practice.

We know that less experienced workers find tools to be more beneficial than experienced workers. And we know that experienced workers feel like the tools limit them to use their own professional expertise. So I think what happens is there is this manipulation that goes on.

I have a colleague who says that child welfare workers sometimes practice with their nose, the olfactory test; how does the house smell? So these sorts of things that they bring with their own clinical judgment to ultimately decide what goes on with families or what is going on with families.

I was having a child welfare worker present to a group of undergrads last week. And this is somebody who has worked in the field for seven years and he said, "Child welfare practice, in deciding what is going on with families, is really based on our own opinions." And that, to me, is alarming. It shouldn't be based on their opinions, it is based on risk assessment tools, which are grounded in research; a supervisor, and the role of a supervisor is to encourage workers to think critically about the work that they are doing; and to be going back to the tools to remind them how the families scored on them. Why have you overridden or changed the outcome that the tool has given us? So to me it is not so much about risk assessment tools it is the integration of those into using our own clinical judgment.

COMMISSIONER MARTIN: I want to tell you that each of the Commissioners, basically, have a question, so we are going to try to be concise.

DR. DOUGLAS: Okay, and I will do my best to provide concise answers.

COMMISSIONER MARTIN: Thank you. Commissioner Covington?

COMMISSIONER COVINGTON: Professor Douglas, thank you so much. I have a question and it is something I have been trying to get at for a very long time. And I have heard it many, many times in my world, and I think it is true, which is that children who die are not that different, when you look at them, than kids who are severely injured or neglected, and that it is really difficult to predict in a caseload children who may end up dying versus others because we haven't been able to differentiate that. Can you help me with that? Because it makes me think that why only one state had a section on fatal child maltreatment fatalities is that they are trying to just get workers to identify kids at risk in general. So can you help me figure out why it should even be looked at differently?

DR. DOUGLAS: Well right, it is true that if you prevent child abuse and neglect you are going to prevent child abuse and neglect fatalities. I have heard this too, I have heard workers say this and I have heard this from professionals in the field and when I have given presentations; that they are not really that different. I'm not sure that I agree with that. When anecdotally I look at cases where children have died who are known to the child welfare system there are red flags everywhere. I mean, it is, retrospectively, so clear that this child is at risk for dying. Yet when it is happening, the workers are not seeing it. And that is why I think workers think that they look the same as other cases. I think they are not bringing a fatality lens to it. I think that if I would want workers to know three things I would want them to know that little kids die, that kids die of neglect, and that moms are most likely to be responsible for their kids' deaths. And workers do not know two of those. They know that little kids die, they think that kids die as a result of physical abuse, and I think they think it is because of mom's boyfriends.

COMMISSIONER MARTIN: Commissioner Bevan?

COMMISSIONER BEVAN: I also teach at a social works school. Many of my colleagues say, "Social workers' decisions are no better than a coin toss." Would you comment on that?

Because you said a lot. I mean -- and so much of decisions, as you know, are important and I sort of tend to agree that I don't think the social workers' decisions, especially the fact that they are the gateways to services, they are the gateways to the fatality lens, are they better than a coin toss, 50/50?

DR. DOUGLAS: I live to believe that they are better than a coin toss. I mean, there is so much work to bring research into the field. I mean, the field is often ideologically driven, we know that. Bringing in a strengths perspective is an ideological position. It is not based on research. But I think at one time maybe it was a coin toss, but I think that it is better, but that is based on me sort of watching what goes on in the training of students. I participate in foster care reviews, for DCF in Massachusetts, and workers are making efforts to integrate research, evidence, and risk assessment tools. So I am not comfortable saying that it is as good as the coin toss.

COMMISSIONER AYOUB: I hope to feel confident in the answer to this question because over the time that we had meetings with this Commission I have heard different answers on this, and you seem very confident in your answers so I want to believe you, because I don't want to ask this question again. (laughing)

On the perpetrators, we have had most experts. What I have heard is them saying that it is usually the boyfriend. At the last meeting, there was one expert who said it was the biological father, and now I am hearing strongly that it is the mother. Can you clarify the discrepancy in the experts?

DR. DOUGLAS: The NCANDS data consistently shows, year after year, that more children have experienced neglect than abuse before they die. Now the truth is, the NCANDS data does not record the type of maltreatment from which children die. All they record is that the type of maltreatment children are experiencing with their involvement with the child welfare system. It might be a leap to say that children are then dying from the type of maltreatment per the reason they are involved with the child welfare system. But consistently it shows that children are more likely to die of neglect than abuse.

Those stories do not make it into the media. In those stories there is a lot more gray area; children falling out of windows while the mom, who is depressed, sleeps in the other room and there is no screen on the window, or a parent who leaves her child in the car so she can go to a party at night and the child bakes in the car, or a parent who leaves a 3-year-old to supervise a 9-month-old in the bathtub. That is a recipe for disaster. That's a form of neglect. But individuals could say, "Is that an accident?" I think that most child welfare professionals in the examples I have provided would come down on the side that those are instances of neglect. But we don't hear about them in the media. What we hear about are kids being shaken, and beaten, and suffering terrible physical abuse. So I no way want to take away from the physical abuse that children suffer, but neglect has been neglected for a very long time.

COMMISSIONER MARTIN: Commissioner Rodriguez?

COMMISSIONER RODRIGUEZ: I want to comment first that I think on the smell test that is particularly alarming is because the profile of social workers sort demographically and socially is so different from the demographic profile of the families and children.

DR. DOUGLAS: Absolutely.

COMMISSIONER RODRIGUEZ: So there really isn't an ability to imagine what the life of that family or child is actually like on a day-to-day basis.

That was my comment, but my question was are you able, in your research, to piece out at all...when I am listening to the way that the workers responded I am sort of not clear about whether the issue is really, in fact, that they missed the warning signs or whether they missed or did not have the ability to develop a plan or an intervention that adequately responded to the warning signs. Did your research attempt to tease out those two?

DR. DOUGLAS: It did not. No. I mean, it is a very important question. When a worker has seen warning signs, what is it that they have done next? Or if a parent says, "I think I'm going to kill my child, that's all I know," but what did the worker then do? Did the worker consult with her supervisor, and I don't know. That is such an important next area for research.

COMMISSIONER RODRIGUEZ: Because I think, even the experience level of the workers doesn't necessarily tell us what we want to know about general experience as a child welfare worker, for example, handling a caseload of children who are in long-term foster care. It does not prepare you with the skills and the experience that is necessary to go in and investigate abuse or neglect.

DR. DOUGLAS: Yes.

COMMISSIONER RODRIGUEZ: So I think that is where I'm struggling to figure out what this means.

DR. DOUGLAS: Right. We don't know. If somebody said that, they have been working for DCF for six years before this child died in their caseload it might have been doing adoption services, right? They might have been placing children in adoptive services. I mean, my guess is that was probably true for some of them but not on average.

COMMISSIONER MARTIN: Commissioner Petit?

COMMISSIONER PETIT: Yes. Thank you. That was a very helpful presentation. Just a comment, because it doesn't sound like you have broken it down, that children are typically with their mother as the principal caretakers. And I don't know if it has been broken down between physical abuse, and the blunt force trauma especially versus things like safe sleep, versus going out and leaving a child behind. But my guess, just from looking at a lot of cases myself, is that the blunt force trauma tends to be more associated with and inflicted by men and that the neglect tends to be more by women.

DR. DOUGLAS: Yes.

COMMISSIONER PETIT: So in terms of what is making the news, typically what is making the news is the blunt force trauma and kids being thrown down (inaudible) and et cetera. So it looks like men may be more so than the other.

DR. DOUGLAS: Yes.

COMMISSIONER PETIT: But that is not my question. The 1,000 to 1,400 kids that died during these caseworkers' watch, is that where you got the 30% to 50% previously known to CPS or is that the NCANDS data.

DR. DOUGLAS: NCANDS does not tell you. What NCANDS will tell you is if this child is a prior victim. That is all that the NCANDS data will tell you. In fact, the NCANDS data, if you look at all of the deceased children in the NCANDS data you can't tell which of them came into the NCANDS data because somebody called in a child has died. So, in fact, they may not have even been involved with the child welfare system prior to their death, but they could still be in the database because you want information on it.

COMMISSIONER PETIT: I think the 30% to 50% number that they come up with in NCANDS is based on their involvement with family preservation services.

DR. DOUGLAS: That is not my understanding, no. The 30% to 50% does not come from NCANDS, because I don't know how you could derive that information from the NCANDS data set. They don't have those variables there. So that just emerges from the literature. That is based on my review of the literature that it is 30% to 50%.

COMMISSIONER PETIT: But what about the cases that you have? Of those 1,400 cases did you go back and look at which of those were known, and how did you define it being known to the department? Referrals, investigations...?

DR. DOUGLAS: I think that maybe I may have created a little bit of confusion. You can go to the NCANDS data and you can see all the children who have died. The only thing you can parcel out is whether they have been a prior victim in their system. Then you could look just at those cases then. Does that answer your question?

COMMISSIONER PETIT: I think it is...

COMMISSIONER MARTIN: Wait just a second. Did you ask the question that you wanted to?

COMMISSIONER PETIT: Well I wanted to respond to that. No, it doesn't answer the question, which is not any doing of yours or a shortcoming of your data; I think it is a need to reexamine what that data says in a more detailed kind of way. But you did say something that I would like a reaction to. You said that among the kids that were killed, one of the principal signs, I thought you said was they had been in and out of the system previously. They had been in and out of foster homes.

DR. DOUGLAS: The literature shows that having an out-of-home placement at some point in the child's history is a risk factor. That does not come from the NCANDS data that just comes from sort of the body of literature in general. But could you capture that with NCANDS? You could, if you looked at it longitudinally you could capture that with NCANDS, yes.

COMMISSIONER PETIT: Yeah, I think that the concern for me, and this is one that we are all going to have to wrestle with, is that unlike any other indicator involved with children, this measurement is per 100,000 children.

DR. DOUGLAS: Yes.

COMMISSIONER PETIT: Not per 1,000 children. So this is actually still a very infrequent event. But the question then becomes what about the children we do have in care in one fashion or another? Those are open. They are not part of the 100,000; they are a part of a much smaller subset. In other words, there is a group of children that right now we have them in front of us.

DR. DOUGLAS: Yes. Right.

COMMISSIONER PETIT: And that is the group of children that is most likely to face death and that we have identified families that they are involved with. So whether the response is appropriate or not, that is the group of children that are most accurate.

DR. DOUGLAS: Right. So what you are saying is that the base number shouldn't be living, live children, it should be children who are experiencing maltreatment right now.

COMMISSIONER PETIT: Correct.

DR. DOUGLAS: So that should be your base number.

COMMISSIONER MARTIN: Commissioner Horn? Real quickly.

COMMISSIONER HORN: So first of all, as a former front line caseworker, almost everything you said was completely true. I'll take the "almost" out of it. Everything you said is completely true. Fortunately, I have never had a child death, but I certainly had some sleepless nights worrying about it.

I think the risk assessment tools, unfortunately, sometimes give inexperienced people, like me when I started out, a level of confidence that is not really warranted. But here is my question about training, because as somebody who had a Ph.D. and went and became a front line worker, I did not feel adequately trained to be able to make a differentiation between which kids are safe and which kids are not safe, and it depends on the swing. What happens is you read something in the newspapers, something happens, somebody else's case in your agency, now you are pulling everybody out of the home. Then suddenly there are too many kids in foster care and nobody is getting pulled out of their home.

DR. DOUGLAS: That's right.

COMMISSIONER HORN: So you said three things, but I want a little bit more. What would you tell people in training that would fundamentally change the way that they approach this issue?

DR. DOUGLAS: Well, I would first want to make sure that they know what the risk factors are, the conditions under which children die, and how children die. And then I would want to have a conversation about how risk and strengths can be present in families at the same time. Because I really have the sense that workers believe that if you have a risk and you have a strength they equal each other out.

COMMISSIONER MARTIN: Thank you so very much for your testimony this morning.

DR. DOUGLAS: Thank you.

COMMISSIONER MARTIN: Ladies and gentlemen, we are running behind just a little bit so we will take a 15 minute break and then come back for the next panel. Thank you so very much.

PROCEEDING RESUMED

COMMISSIONER MARTIN: Ladies and Gentlemen, can we get started? I was telling the staff that I have neglected to keep us on time. So in an effort to kind of make up some time here I'm going to have to ask the speakers to shave one minute just so I can give enough time for questions and answers. You can see that the questions and answers are the part that I haven't controlled very well, so I do want to give everyone an opportunity to ask you ample questions about your presentation. This afternoon, ladies and gentlemen, we have a panel before us. At the present, I am not going to introduce each individual person with their bio; I will just say their names and allow them the opportunity to go in order of their presentations.

We first have Ms. Theresa Costello; she is the Executive Director for ACTION for Child Protection, with Kyle Hoover. Kyle is an Investigator Assessment Social Worker. We have Shawn Vetere, a social worker, and we have Matthew Bergeron, a social worker.

Very well, please, if you don't mind.

THERESA COSTELLO: Thank you. First of all, I would like to say thank you for the opportunity to present to you today, and I welcome the chance to share with you and experience some observations that we have made over the years, and contextually I just want to say that as the Executive Director of ACTION I have been, recently, over the past 15 years, involved in the National Resource Center Network, the Children's Bureau-funded whole group of resource centers. So we have the opportunity to serve, actually, with the Child Welfare Institute as the National Resource Center on Child Maltreatment, and then we became the National Resource Center for Child Protective Services. I tell you that because contextually many of the things that I will talk about are based on the observations and the opportunity we had to work with states over the past 15 years in their safety assessment process.

What I plan to do in 29 minutes is to go over, very quickly...and no presentation about safety can be done without talking about risk first of all so we can distinguish the two of them. So I will talk about the most common current approaches to safety assessment and safety management, look specifically at safety decision points. I am going to touch on the ASFA [Adoption and Safe Families Act] and CFSR overlay...that will make you happy, Commissioner Bevan, with safety decision making, and look at some of what I consider to be strengths, limitations, what research I think needs to happen, and some observations about safety assessment and fatality prevention.

So as I said, risk assessment—we already had some overview of that so I am not going to go into that. Essentially, risk assessment in child protective services was introduced in the late 1970s, and it was primarily introduced because we face the challenge of having too many families being referred and having to have some way to prioritize. So they were really a set of guidelines that were used to optimize the use of our scarce resources, "Which families are we going to be able to serve? Which families present the highest risk and therefore should be prioritized?" So that was the reassigned why risk assessment tools were created.

I put on here at the bottom just to really point this out immediately that risk, by definition, the risk in child protective services business, equals the likelihood of maltreatment. That is what risk assessment tools are designed to tell us, what is the likelihood that this family will maltreat their child in the future if we do not provide an intervention to that family?

This was already mentioned by our previous presenter, but there are actuarial tools created for risk assessment, which are really classification tools. They are based on the same kind of process that is done to determine your car insurance rates and what is the risk of the driver that is going to drive that car. So if you have a teenage son you are going to pay a lot more than if you have a 50-year-old woman driving the car. The same kind of thing as actuarial risk assessment tools; classify families according to factors. There were also what I would call theoretical empirically guided tools and some consensus-based that were developed for risk assessment. So they had a research-informed basis to them but they were not developed in the same actuarial method.

So that is the kinds of tools that exist in terms of risk assessment, and I know the rest of the panelists here will speak to you about Vermont's particular approach to risk assessment. But what I really want to do is I want to focus strictly on safety assessment from here on out. That is, in my opinion, a very important consideration for the Commission in terms of thinking about fatality prevention.

Historically, the concept of safety was first introduced in 1985. My former boss, Wayne Holder, and Mike Corey, who were the founders of ACTION for Child Protection, were making a presentation at a Child Welfare Institute conference and really came to sort of the grand thought that we are talking about risk, but we really need to be distinguishing a different concept from risk. It is related, but there is a different concept that we need to be thinking about when we are talking about families and immediacy and severity of concern for certain situations in families. So the idea of safety as a distinct concept from risk was birthed at that point and time.

The Edna McConnell Clark Foundation was fundamental in providing some research in Anne Arundel County, Annapolis, Maryland, to test out one of the first safety assessment tools that existed. So we did that and it really gave us some knowledge base to move forward. What I put up here on the screen is what I believe are currently pretty widely accepted definitions for the terms "safe" and "unsafe". Some important things to distinguish in here are the definition of a "safe" child is, "Vulnerable children are safe when there are no threats of danger within the family or when the parents possess sufficient protective capacity to manage those threats." And conversely, an "unsafe" child is one in which, obviously, there are threats of danger, the children are vulnerable to those threats, and the parents have insufficient protective capacities to manage those threats. These definitions, I would say, are universally used these days and even in the various approaches to safety assessment, which I will talk about.

When we talk about the concept of safety, the reason why we define "safe" and "unsafe" is because safety is like health, you can be healthy or unhealthy. So it is the concept of "safety". That word is used frequently but it is the definitions, such as these, that get us into, "What do we really mean when we talk about whether children are safe or unsafe?"

This next slide I put up here, this is one that we use frequently. The judges guide, which I believe you all received as a reference material in your packet, which was put together by

the ABA [American Bar Association] and the NRC for CPS, is something we have used frequently to explain this concept. We do a simple equation, not to say that we think it is a simple decision. It is not a simple decision. It is a complex decision, but what we want the workers to get is the ability to do, as a decision-maker, is to understand, "What are the threats of danger? Do I have a vulnerable child that is susceptible to those threats of danger, and do I or do I not have protective capacity within this family?"

So you see the formula with the equation you could have a plus on that protective capacity and you would have the result of having a safe child. When you have a minus on that formula, you have an unsafe child.

This is a concept that we use to help to say, "These are the three most important components in understanding safety in every single family that comes to the attention of child protective services. When we talk about protective capacity, and I am not going to go into a lot of detail about that, in reference to what the previous speaker said, and I think what some of my colleagues up here will say, we are not talking about generalized strengths, we are talking about specific behavioral emotional and cognitive protective capacity that has been demonstrated by the caregivers in that family to provide protective action for those children. So it is a very specific assessment of the cognitive behavioral and emotional capacity of the caregiver, not a generalized sense of strength in the family that comes into this assessment in this kind of equation approach.

The next slide I put up here, and this is again something that you will find in the Judge's Guide that you received as a reference material, there are different approaches to safety assessment and there are different tools. This list is based on our best collection of all the tools and what we would consider to be universal safety threats. These are the kinds of threat descriptors that are found on almost every tool that you will come across; violence, parents or caregivers that hide children and make them inaccessible, lack of self-control, which can include substance abuse and all sort of different things and could even be a mental health condition that is so out of control, distorted or extreme perception and failure to supervise. I am not going to list them all, but these cross both physical abuse kinds of maltreatment situations as well as neglect situations. One of the things that is important, just based on what we talked about earlier, and you will see the item on here, "child provokes maltreatment" in the list of risk factors for fatal child maltreatment. That was one of the things, the difficult child or the provoking behavior. That is a safety assessment safety factor you will find on most tools these days. So this list is given to you to help set the stage for what we believe are the current types of "danger threat" that are being used in decision-making in child protective services currently.

I wanted to mention I put a few slides in here because I think this is very important and I think it has given emphasis to and placed the right importance on safety as a clear decision-making focus in child protective services and that is ASFA and the Child and Family Services Reviews. So this list is what the ASFA requirements really lay out where safety assessment must be assessed at each point in the life of a case. I am not going to talk about these in depth, but I am going to say a couple of things.

Timely response. This comes in the CFSR measure where we have the timeliness of our first response as a safety response. If we feel the child is unsupervised right now, the parent has a meth lab in the kitchen, and we have an urgency to the timeframe, that is a safety response.

Preventing recurrence is a CFSR requirement. It is a safety response. We are trying to prevent the subsequent incident of maltreatment within that family.

Reunification. Assessing safety at investigation is an ASFA and CFSR requirement. It is spending reasonable efforts to keep children safely in their own homes, so not at all costs, but how do we assess for safety to see if they can reasonably be kept in their own home?

ASFA and CFSR are services to protect the children in their own home and to prevent removal. That is a CFSR measure and it comes out of the ASFA requirements.

Assessing safety in out-of-home placement. So it is not just our responsibility to assess safety in a child's own home, but if we are going to place them outside of their home that is also a safety decision.

So continuing maltreatment out-of-home placement, assessing safety in the case plan, and then the time limits and assessing safety at reunification. I lay all of these things out because I think that they are important. What we have seen is the emphasis on safety has been brought to us not by just the need because we know what it takes to make good decisions but because we have requirements that tell us there are key points in time in which safety has to be the focus of our work with families. And one of the important points I want to make is that it is not safety at the expense of well-being or permanency, it has to be the woven-together of safety, permanency and well-being, which is why we see in this last point the time limits that we have for making decisions. You mentioned this earlier. It is because we want to have a focus on well-being so we have to be sure that we have precision in our safety assessment and safety management process so that we are building the protective capacity of the caregivers in order to capitalize on the opportunity to have them focus on well-being with their children. So all that to say that the ASFA requirements are a clear foundation for our important focus on safety assessment.

Safety decision points. These are the current points in time in which, if you go to any given state jurisdiction and you look through their policy procedures and decision-making tools you will find, in a best practice sense, a focus on safety. This slide lays out how you might see that. I already mentioned at intake a hotline response time. You are going to see a focus on the urgency of the time of response, but any state that is doing differential response will be making a distinction at the point of intake; those cases in which we believe there is an immediate safety concern in that call versus those cases in which we believe there are more generalized risk concerns and making a distinction of an assessment versus an investigation along the lines of keeping in mind safety.

Initial contact. That's a "present danger" kind of focus. One of the distinctions that has been made in safety assessment as it has evolved is the distinction between present danger and impending danger. The point is that at first contact with the family, when a social worker goes out and begins, they are looking for anything in this environment that represents an immediate threat to this child. Can the child stay here right now? They also have to complete their investigation and through the course of their investigation they are then assessing for what we consider to be impending dangers. What are those things that are not happening in my face right now but could represent a threat of danger to the child at any point in time? It is things like domestic violence. Domestic violence is probably not happening at the minute that the social worker is in the living room, but we may learn that there is a pattern of violence in this family that represents what we would consider to be impending danger.

We also see decision points related to removal and reunification. Those are safety decisions. Stepping up or stepping down our intervention with the family so that if we have a child that is removed and we can bring that child back home with an in-home safety plan that is a safety decision that is a step down from removal to an in-home safety plan where we continue our intervention with the family as we move towards continued work with the family. In ongoing cases we have a focus on safety assessment for both in-home cases and out-of-home cases.

Visitation. In and of itself, the reason why we do supervised visitation is because we have concerns about safety. If we don't have concerns about the safety of the child in that visitation situation we would have an unsupervised visitation allowed.

So it is these kinds of decisions throughout the life of the case that all need to have a lens related to safety assessment.

In the practice these days out in the world there are really three different kinds of approaches or models that are being used for the assessment of safety. The first one at the top of the list, which the Vermont team will talk to you about is SDM [Assessment of Danger and Safety Tool]. The Children's Research Center is a decision-support system that includes an actuarial risk assessment tool, safety assessment, risk reassessments and safety assessments later in the life of the case. It is a system that focuses on classifying families according to the level of risk and then also allows for the individual assessment of safety in the early part of a case as well as safety assessment throughout the ongoing part of the case.

The second approach, which I put up here, is called "Signs of Safety". I think you have an article about that. Andrew Turnell and Steve Edwards out of Australia created this. It is what I would describe as more process-oriented. It is not a list of safety factors it is a decision-making tool in the traditional sense of it, but it is based on brief solution-based casework and it is a framework for engaging families. It is meant to be used to sit face-to-face with a family and map out the worries, the concerns and those things that the family feels have worked in the past, those things that they believe will work in the future. It is different and very user-friendly methods for engaging parents and children in understanding safety within their family.

Then the last approach is the safe model, which is the safety framework that we have developed over the years. It is a series, again, of decision-making tools that are focused on assessing, as I said, present and impending danger as well as protective capacity. One of the key features about the safety assessment approach that we worked on over the years is that, in the ongoing part of the case, the ongoing worker is focused on understanding how to enhance protective capacity in order to reduce the safety threats that exist in the family. So it translates the safety concerns into the treatment case plan focus of the case so that there is a specific way of working on enhancing protective capacities with the family.

What I would consider to be strengths of current approaches taken sort of at-large is I believe we have in the field greater consensus on what the safety threats are. This is something that Tom Morton and I were just talking about. Unlike risk assessment, there will never be an actuarial safety assessment tool. The base rate for present and impending threats of serious harm cases, thank heavens, is very low. So we are not going to have the same kind of process done to come up with actuarial science methods to come up with safety assessment tools. They are going to continue to be consensus-based, evidence-informed or whatever you want

to call them. So it is a different kind of process, but we do have consensus on the safety threats, I believe.

We also see what I would consider to be good and consistent practice on assessing for present danger, what is happening right now. Most safety assessments are required to be completed within 48 hours of face-to-face contact with the family. We see that implementation is improving in terms of implementing these. I'm sure you have heard, and I am sure that most people would say with any kind of decision-making tool the biggest challenge is having it used with fidelity. There are many, many tools that are implemented and never used the way they were designed to be used or to guide the decisions that they are supposed to be guiding.

I think we are seeing an increasing emphasis on family engagement. I think the signs of safety approach has really added to that in terms of how we understand and engage families in understanding safety from their point of view. We are also seeing some hybrids of safety assessment approaches. It is not uncommon to go into a jurisdiction and see a mix of the SDM model and Signs of Safety. In Florida, we have a mix of the ACTION safety approach and the SDM risk assessment approach. So we are seeing more hybridizing and sort of bringing these different models together to work in practice in different jurisdictions.

Limitations of current safety approaches—I believe there continues to be confusion on safety versus risk. Every kind of training situation that I get into, some of the questions I hear, some of the policies I read continue to mix the terms of safety and risk. So I believe that is still an area we need to work on. We see less precision and less good work in terms of assessing for impending danger. I believe there is a need for an ongoing emphasis on beyond that first contact and the early days with a family in a CPS investigation. There is so much more that we learn throughout the rest of the investigation or the assessment process, and there is even more that we learn as we get into the ongoing stages of working with the family that we have to go to continue to keep our impending danger framework in our lens open as we continue to work with families and have a formal way of assessing for that.

The other thing I think is really important—safety management. I use the term “safety management” as a function and I believe that it is not well understood in practice these days. And I say that because when a case is handed over to an ongoing worker we frequently see a drop-off in the attention to those things that are what I would consider to be related to safety management. I don't mean just redoing the safety tool every now and then, I mean, continually staying in tune for those kinds of things that may be bringing the family to that point where we would consider the child to be unsafe, where we are seeing a rise in the threats, where we are seeing a lack of protective capacity and we are seeing an increase in vulnerability of the children in the family. That piece of it seems to be still in need of work in our field.

The last thing is reunification decisions are not always safety-based. If you go across the country, and everybody is nodding their heads, it is so common that we see decisions about reunifying children to be based on complete the case plan, have an apartment for 12 months, get your GED and things that are not necessarily in any given family threats to safety, and yet we see this “raising the bar” so that reunification for families becomes impossible or much longer because we are not keeping the focus on what are those specific threats existing in this family and how can we look for the behavioral change in the care givers to give us confidence that we have seen change from the point of protective capacity in order for reunification to happen.

So challenges. I would say that one of the things we have seen and continue to see is implementation. Many, many good decision-making tools, models, practice models and structures have been created all over the place and yet implementation of those has frequently not been successful.

The second bullet I have up here talks about implementation science. That may be something that you have heard about and that the Commission has had a presentation about. I believe that it has shown the greatest promise in terms of helping us to really implement decision-making tools more effectively. It is a very solid approach that says that you have to focus on different drivers. Traditionally, we have thought that training is all we need to do to develop the tools, write the policy, train people and send them out there and they are going to do it. That is not the case. It doesn't happen that way and the tools don't get implemented with fidelity. So applying what we have learned from implementation science has, I believe, a great deal of promise for us. Along with that, we have to recognize that it takes many years, money and resources and leadership. I will say that again, it takes leadership to implement major kinds of decision-making tools and processes like a comprehensive safety assessment approach, and that is something that our field is challenged with because we see a lot turnover and we see changes in leadership. We see, as this Commission is looking at, fatalities that come in and we see changes all over the agency in terms of leadership and policy that is developed based on a one-case situation and those kinds of things. So leadership that is focused on implementing the decision-making model with all of the pieces that are necessary, I think, is important.

Research needed. I believe that we do need to have some rigorous research on safety models and this is not easily done. I just wanted to mention there is one study that is underway; the Children's Bureau funded the Permanency Innovation Initiative (PII). A number of different projects, and right now, currently, in Washoe County, Nevada, there is a true controlled group design that is testing a safety assessment model. It has got random assignment of cases, random assignment of workers even to the controlled group. So it is testing "business as usual" for safety decision-making versus the safety assessment approach. It is the first rigorous research design that I am aware of that has been done on safety, so I think that will be good for us. The results of that will be out in about a year. I think we need to have better work on inner rater reliability of the safety assessment tools that we have.

Construct validity. Casey is helping to support some work in Florida on the new set of decision-making tools that are a combination of risk and safety in Florida. That will help with inner rater reliability and construct validity of the safety assessment tools, including a scaling of the protective capacities. It is the first time that has happened.

Then the last piece on here is fidelity assessments. I believe that it is important when something is implemented to begin to look to see is it being applied with fidelity at this point in time. So is that present danger assessment being applied the way it is supposed to be? Is the impending danger assessment being applied the way it is supposed to be?

The last points I wanted to make in terms of the specific focus that you have on fatalities and serious harm types of cases is I believe that it is not realistic to think that any specific safety assessment safety tool will have the predictive accuracy to prevent maltreatment-related fatalities. I just don't think that they are designed to do that and I don't think that is a realistic expectation. I think we should see tools as guides to decision-making and that we

should strive to make them better in some of the ways that I have identified; more consistency and some of the research that we need. But I think it is equally important that we focus on staff skills, engagement, and the process that the worker and the supervisor are engaged in. We frequently are involved in reviews of cases, and not just fatality cases but all cases, and we often make the same observation that was made by our previous speaker; that there is all of the danger threats that we would say are on the safety assessment tool present in the case and yet they don't seem to have been understood and then planned for in the safety plan that took place. So where is that critical thinking piece? What is happening and what is being missed in terms of how that translates from the decision-making tools into the understanding of what needs to happen next in terms of the planning and the action that the agency might take.

Then the very last point I put up here, and I believe that it is something that was put in your packet, I worked with the state of Hawaii recently on a special protocol. They were challenged with the cases in which they had unknown perpetrators. There was serious harm to young children and they didn't know who had done it. There was more than one person who had access to the child at the time that the child received these serious injuries. As a result, they ended up developing a protocol, which is more than about unknown perpetrators, it is about serious harm. So it really addresses the near-fatality and I think it is especially thoughtful about what are all the pieces that need to be taken into account, and it is much more than just the decision-making tools for safety assessment, it is about all the other parts of the system that can come together to help understand that family and then monitor the intervention that is happening with the family as the case proceeds. So I encourage you to look at that in your reference material.

COMMISSIONER MARTIN: Thank you, Ms. Costello. Mr. Hoover.

KYLE HOOVER: Good morning. My name is Kyle Hoover and I am a social worker with the Vermont Department for Children and Families. For the purposes of time, I am going to cut a bunch of the speech. I had some great attempts at making analogies for you guys that would relay the realities of the work, but I'll sum it up by saying I really couldn't find one. (laughing) I think the work speaks for itself and there is really nothing like that feeling that we get. So bear with me, because I am going into reading the statement, which I feel kind of embarrassed about as a social worker. But this is my attempt to engage you and keep it succinct.

I talked about that feeling and that experience in responding to allegations of abuse and neglect. That feeling you get just after getting a case at the end of the day, driving around in the snow down a road where no one has even heard the words "cell phone tower" and then knocking on the door of a run-down compound, hearing the bark of a huge animal and at least four more voices than you were expecting on the other side. That feeling that refocuses you in that moment, drawing on past experiences in your training and whatever tactics that you could use to get inside that home and engage and effectively gather detailed information while accentuating those protective capacities and making immediate decisions around safety.

Then we couple that with the underlying feeling that we just don't have the time. We don't have enough time to plan, we don't have enough time to effectively respond, and we don't have enough time to type and type.

So it is that feeling and not an analogy that I want to use as my starting point for talking to you about the initial assessment of child safety. I hope to give you an overview of how Vermont assesses safety and the strengths and the process, and what I see as some areas of need as well.

In Vermont, the assessment of child safety starts with a call to our centralized intake unit. Reports are taken, entered into a system by social workers and reviewed by a group of statewide supervisors and accepted for assignment as an investigation or an assessment to the local districts. Reports are also screened by a local supervisor who can also accept a report on second read. A case is given the priority level, which breaks down basically into needing a response, by the end of the day or within 72 hours. At minimum, we interview the alleged victim, other children in the home, caretakers, potential witnesses, supports and the alleged, in addition to conducting a home visit and a site visit, if needed.

Our practice emphasizes the structured decision-making tools that Theresa talked about, and what we use is the SDM Danger and Safety Assessment that I believe you have a copy of. That tool needs to be completed within 24 hours of our initial response and it assesses whether a child is safe with the plan, or unsafe.

The SDM risk assessment tool is then to be completed at case closure, which we try to keep it 45 or 60 days, depending on the case type. This tool dictates whether there is a likelihood of further maltreatment, which means DCF should remain involved with the family for a period of at least three months. When responding to a report I had immediate access to the complete DCF investigative reports back to about 2004. I can also review case notes for that time frame, which in Vermont also includes our Juvenile Justice. A limited database also shows some basic substantiation runs and substantiation decisions for past cases as well as maybe some previous case types we have had with the family. I can access court dockets, Department of Correction information and I can have administrative staff look for economic services records to find out benefits of the members of the household, and for even contact information if that is absent in the report.

Over the years, I have also earmarked some online databases that include federal court documents that I can access. Some states do provide their correction database information for the public knowledge and then, of course, there is Facebook.

Our district also has a great relationship with the State's Attorney in our county and law enforcement, so I am often able to get those police reports or even hear about pending law enforcement concerns.

Our investigative unit. We also gather information about sex offenders, so we obtain charging affidavits or treatment histories, we scan them and compile them online so we can easily access it for using in the future when we have a risk of sexual abuse investigations. But all things considered, it is rare that I have time to fully vet these systems and internalize such information prior to an initial response, but is something that I do strive to complete in most cases prior to closure.

Within this process, there are some areas worth highlighting, I think, to the Commission. As a filter or centralized intake model has addressed inconsistencies across the state specific to acceptance rates and caseload type, still those second reads are kept to keep our community

engaged and to have our partners understand the familiar faces looking at their concerns as well.

In practice, I also find those SDM tools to be efficient and their structure to allow for focused planning and consistent response across the office. They help reduce blind spots and elicit further discussion about protective capacities that might have otherwise gone undone. The risk assessment is supporting research and also allows me to engage with families because we can go over those specific things that show why there is an increased likelihood of maltreatment and so we can have those open discussions that are based on research.

I also find that advances in technology, like having access to all those records for the last ten years, to be extremely beneficial. So armed with my i-Phone and actually cell coverage, which again is not a given in our state, I am able to run a new household member through the system or even have a supervisory coworker run the full history and email it to me. It is also worth noting that the inclusion of the Juvenile Justice case notes and moreover housing such cases within Vermont Child Protection is extremely beneficial. Such history and its effect on immediate child safety including to younger siblings or with the juvenile's own child is extremely important.

But one of the most important strengths I want to convey to you is embedded within the practice. Beyond policy, it is essential in addressing in serious cases, including child death, and that is the presence of multi-disciplinary teams and all various intonations of that idea. Whether it is our local Child Advocacy Center with the various and paneled teams that share common goals related to children, these are places where relationships are built, opportunities to improve local practice evolves, and there is a shared stake in improving protection across disciplines. Even on a statewide level, because of such processes, DCF workers are unified with nurses, doctors, hospital staff, and the Department of Health in preventative language around Shaken Baby or even unsafe sleep practices, and I believe a such a model is absolutely critical to my work and worth the extra time it takes to build and sustain those relationships.

As will always be likely in Child Protection, which I really see as a draw to this work, there are areas for examination and improvement. One of the major areas of frustration I experience in attempting to assess safety is the sharing of historical records across child protective agencies from state to state. From my office I can drive 15 minutes and be in two other states. Add an hour and I can be in a third. And yet when we talk about collaborating and sharing documents it could be a world away. Vermont has clear statutes where we are able to share information with the proper authorities without hesitation. Some other states may acknowledge the history or they may not, and they may have clearinghouses that take months or weeks to actually obtain the records that we need.

For our small state, with a bordering population that is in transit and babies that are born in our hospitals from out-of-state residents this is an extremely difficult obstacle to the process. So somehow, creating an agreement for uniform quick sharing of information could greatly benefit our work. I also believe there are some issues and inconsistencies of responses that to me are rooted in the different makeups of our system. A judge, a prosecutor, or even a community agency may greatly affect child safety beyond any policy, statute or research-based tool. This is particularly evident with the decisions around removing a child from a home, as practices vary even within Vermont. It is also a factor within the system to don't

communicate with partnering agencies as they operate in tunnels without the benefit of recognizing a shared common goal.

Then there is worker retention. Be it supervisors or direct staff, it is a real factor in how we assess child safety. Those tools that we talked about can be overwhelming and feel completely subjective to a new worker. What's more, the complexities of the work can become manageable and even exciting the more experience and time that a worker has in the field. Those important relationships that I talked about with the community members or even within the office are only built over time, and yet this field is fraught with burn out, secondary trauma, high caseload and underpaid, long hours. Continued research for best practices, focused training and examining caseload size would be extremely beneficial.

Last, I think it is also important about the realities of funding or lack thereof. We all recognize, in terms of child deaths, the most vulnerable population is infants and toddlers. Those non-verbal children benefit from having proactive services not limited to visiting nurses, pediatricians and day cares wrapped around them and being their true voice. Parent substance abuse history violence in the home, or mental health issues that co-occur also require adequate treatment options. Without the proper funding we have wait lists or altogether lose the ability to serve a child and keep people around that can be that voice.

So in conclusion, I think we all want to keep children safe, we all want to reduce further risk, and we want to strengthen families. I think it is in that order. In my experience, reminding ourselves of this and taking the opportunity to examine just how we do it is essential and refreshing. So again, I want to thank the Commission for allowing me the opportunity to briefly share my thoughts and I will now turn to Shawn, who will talk about her role as an ongoing caseworker.

Shawn Vetere: Thank you. Hi, my name is Shawn Vetere, and I work with the St. Alban's District Office. I primarily work with custody cases after the children have been removed. So thank you for allowing me the time today to testify about monitoring the challenges of safety in these cases.

First and foremost, caseload sizes, which impact the worker's ability to appropriately address the family issues, have been and will continue to be ongoing challenges that social workers face in being able to adequately monitor safety. It is essential to be able to have the time to conduct intentional and purposeful home visits which last more than a half-hour to one hour once a month. In order to assess safety and to be able to consider appropriate permanency options for the children we have to be able to devote this time to determine if the parents have actually changed or merely complied.

It is crucial to be able to visit the children in the foster homes in a meaningful way to include their voices and assess their needs. However, due to the high caseloads we often have to see the children at the district office or interrupt their school day or visits with their families in order to meet policy.

The family complexities and the unrealistic workloads of this work play a huge role in being able to adequately monitor safety. For example, it is not uncommon for me to have a family with four children, all with special needs, three to four different fathers and multiple foster homes. If I am lucky I will get another worker who will team it with me. We are expected to access the needs of the parents and the children, recommend services, insure the

implementation of those service, write disposition and case plan reports, monitor the progress of these plans, facilitate parent/child contact and monitor that contact when the service isn't available, conduct home visits, team meetings, gather information from providers, engage with the family to be able to determine the change, attend court hearings, testify, and report to the courts on the family's progress, support the foster parents, and based on all of this we must make a determination regarding the children's permanency. This is considered one case for us.

Monitoring child safety is further challenged by social workers not being appropriately trained at the foundation courses that are offered when we are hired. These courses do not represent the true nature of the work and they barely offer a baseline approach to the work. We are not initially trained on how to adequately represent the children's needs in the courtroom or how to testify on the several different hearings that may occur during the life of a custody case. The realities and the complexities that the families face on a daily basis are nonexistent in the trainings. Many families attempt to deny or minimize the safety concerns that have brought their family to our attention. However, social workers are not initially understand the signs of substance abuse, domestic violence, or the impact of trauma, mental health issues, or the substance abuse issues on a child's development to be able to recognize the pattern behavior or how an action might speak differently to what someone is saying.

Also, when we do have the time to be able to go to the training, everything that I just said in the last few statements impacts our ability to be able to be focused at the training. So in addition to social workers not being adequately trained, the providers that we work with are not adequately trained to understand child safety or the risks that the families face. Many providers prioritize family engagement over child safety. Providers withhold information from social workers or will not be transparent in team meetings. Providers do not share their opinions based on their experience for fear that they will compromise their relationship with the families. Community partners as well as social workers also experience a high turnover rate so the families endure multiple workers and essential time is spent rebuilding relationships with the families. These challenges result in a lack of collaboration of goals between agencies, a focus on issues that did not bring the children into custody, fractured and fragmented teams and the ability to adequately assess and monitor child safety. In addition, limited resources, which address the complexities that families face, are another issue in being able to appropriately monitor safety. For many families, safety issues encompass co-occurring issues of mental health, substance abuse issues, domestic violence and sexual abuse. We write disposition plans for the family and make recommendations to help facilitate change. When those resources are not accessible due to long waiting lists or the because the resource is not available because that particular resource doesn't even exist in our community, how do we expect the parents to even begin the process of changing?

Family members can often come forward with the intent to care for their relatives that have entered DCF custody. Sometimes these family members have the same safety concerns that DCF is addressing with the parents or that DCF has historical knowledge they have raised their children in unsafe situations. However, there is no documentation for DCF to offer to the courts regarding these concerns. The worker can testify to this information and DCF can assess suitability, but it becomes more difficult without documentation. As a result, the judge has placed the children with kin that DCF has concerns about through a Conditional Custody Order. In addition, judges have made Conditional Custody Orders, which don't allow for appropriate oversight of the case.

The legal system is an enormous challenge that social workers face in monitoring safety in custody cases. Overworked and understaffed State's Attorney's Offices are frequently unprepared for court hearings which results in the discharge of custody or a conditional custody order of vulnerable children back to an unsafe environment, either at the emergency temporary care or merits hearings. At times, the guardian ad litem have supported the return of the child before safety has been achieved without ever meeting the child or talking to the social worker or caregiver, which often occurs especially with extremely vulnerable children, including infants. In addition, the child's attorney supports the guardian ad litem's recommendations and they have not met their client or the caregivers.

Finally, the parents' attorneys are not focused on urging their clients to change patterns of unsafe behaviors, but only in representing their clients in a way, which usually consists of blaming the social worker for not doing their job correctly, which in turn minimizes the safety needs of the child.

I just want to again thank you for allowing all of us to be able to come and share the challenges that we face on a regular basis.

COMMISSIONER MARTIN: Mr. Bergeron?

Matthew Bergeron: My name is Matthew Bergeron, and I am a social worker for the Department of Children and Families out of the St. Johnsbury District Office. I have been there about 11 years as a front line social worker. We are a bit of an anomaly in our office. We are a very rural section. Most of Vermont is very rural, but this is particularly rural and a very small district office compared to other district offices.

How we distribute caseloads is different as well. We don't silo into front end and intake assessment and ongoing. In fact, as a caseload, I carry what we call a "mixed caseload". I can, at any time, respond to an investigation or assessment. I have ongoing, I have custody, non-custody, I have Juvenile Justice, youthful offenders, and all are welcome on my caseload.

From that framework, that is what I come from, is having a diverse sort of experience working along all the various cases that one can experience while working at DCF as a front-end social worker.

I'm not going to step on anything that my fellow social workers just spoke about, but I want to focus on at least in my district what is ongoing well. How have we addressed this concern around safety and risk? Because it is front and center, I believe, and when we wake up in the morning oftentimes when we go to bed at night we are thinking about our cases, thinking about our clients and worried about when we wake up in the morning what we are going to wake up to.

Risk and safety is front and center. The only clients that we were work with, our clients, are high or very high risk. So out of the gate we have to be focused on the fact that these already, from day one, have a huge amount of emphasis that needs to be placed on quickly identifying and accurately identifying the safety, the danger, being able to communicate that to the families, to the providers and to everyone involved, then creating plans to move forward. And then, during that time, assessing and evaluating where that is. It is dynamic, it

is constantly changing. You know, families are not static; they are dynamic and are constantly shifting, so the evaluation needs to be constantly happening throughout the life of a case.

So some strategies that we, in our district office...and I can't say it has spread to every district office, because there are 12 district offices throughout the state of Vermont, it is not county-based, it is different than other states in that sense. But some of ways that we utilize and we have built in or implemented existing tools and strategies to help us remained focus throughout the life of the case are, obviously, SDM that was introduced to the state several years ago. I find it invaluable in our work and the work that I do throughout the life of a case, whether it be the danger and safety assessment, risk assessments and reassessments, and whether it is the tools that are found on our internet-based system, which we can use to evaluate strengths, needs and risks throughout the life of a case. That is useful in case planning. Those tools are in place and are being used throughout the life of a case in our office.

Things that we do in addition to that, the day-to-day practice, the values or how we keep the values and keep the importance of this front and center is, I think, really the most important thing I want to make sure I relay today. We have really embraced a few very specific practices that I think have helped. One, the teaming model. We have a practice of engaging a family that is different than probably anywhere else in the state. I think other offices are practicing teaming models but I think every teaming model is bit different than the others at this point in the state. Our model is that we have a team, which is comprised of a front-end investigator, an ongoing social worker and sometimes two and we have embedded in our team service providers and in our instance, it is Easter Seals who is embedded in our team. They are, from the beginning, involved, and when I say "from the beginning" it is from when the intake gets assigned and the investigator gets assigned. We meet once a week as a team, but we can communicate as frequently as necessary. We are in communication immediately. If there is support that the investigator needs there is immediate response from the team to support the investigator. So if they are having difficulty getting out to commence we can respond, and because I am cross-trained and have the ability to do that, it's not a problem. So throughout the life of a case. If it is determined that it comes back as very high risk and it is likely that this is going to be opened either as a custody case or an open family case or non-court involved case, than as a worker I would be involved, we would meet, we would usually almost always have a family with the next strategy that we use, which is family engagement meetings. We use family safety and planning meetings, which is really Andrew Turnell's "Signs of Safety". Vermont has adopted it, tweaked it a little bit, and renamed it Family Safety Planning Meetings. Those are used throughout the life of a case, but definitely in the beginning to identify to the family and to all the players sort of what the danger is, what the worries are, and create some next steps moving forward. We also use family group conferencing and family team meetings as family engagement strategies as well.

Other ways that we keep risk sort of front and center is in addition to talking about it incessantly when we are in a team meeting and talking about our clients. I don't necessarily "own". Yes, I have assigned cases on my caseload, but we all share a responsibility about taking a look and evaluating and checking ourselves as to where we are at, or where the family is at in addressing this particular risk or this particular safety. So it is no longer on just the single social worker to make that decision or determination.

Other strategies that we have employed is we have adopted the family time coaching model. That is a model, which, if you are not familiar with it, is a model of not just visit supervision. This isn't a person sitting in a room watching the parent with the child.

What I can say is that I can agree with the need for more social workers. I can agree that this practice is made difficult by the barriers that they spoke to. But I can also say as social workers we are passionate about what we are doing and we are doing everything we can within those constraints to come up with ways to really constantly improve and attend to safety and risk with all our cases.

COMMISSIONER MARTIN: Thank you so very much. We do have a question from Commissioner Sanders who is on the public health.

CHAIRMAN SANDERS: Yes. Thank you, I have three questions that I will ask. I'm getting ready to board my plane, so one is for any of the three social workers, and they did an outstanding job. One particularly for investigation. Do you actually go out in teams with the other workers or nurses, psychologists, domestic violence specialist and et cetera because you are expected to know all of those things? So that is one question.

My second question is the issue of documentation improving that an incident occurred versus concerns that you might have about safety. Have you ever run into situations where you were concerned about safety but couldn't prove it?

And then third, for either of the workers who did ongoing case monitoring, what would it actually take, in terms of visits, for you to feel comfortable that the kids are safe?

COMMISSIONER MARTIN: So I don't believe he addressed questions to anyone in particular, so does one person want to start?

KYLE HOOVER: I can take on the piece about the investigations and then the documents that concern the safety.

We do respond as a team at some point during the case process typically, especially with law enforcement when it comes to any criminal activity or sexual abuse we are responding with that team, but then we are also getting part of that CAC that I talked about that includes a therapist, the case manager and even a medical provider to conduct forensic medical exams. Then we have, at least in our district, a good relationship with our local domestic violence support, and they may join me for a response to a home or even coordinating a safe response for a mother, let's say, in our office where I know there is some sort safe way. Then within the office too there might be times where safety concerns come up and we might have two investigators going out into a home. When a case is more complicated sometimes it is good to have that extra set of eyes.

Then to answer your question about are there times when we have concerns with safety and I can't prove it? I think that is almost on a weekly basis. There are a lot of times where you may not have in black and white the facts but you have the feeling, you have a little bit of corroborative detail, or some things that add up to where you are concerned. So the question then becomes how do we document that sort of feeling but not make ourselves some subjective owner in that process? Then what, ultimately, do we really do with that feeling? I

think that's almost just as key as proving it, at least from my end. So I hope that touches on the Commissioner's questions.

COMMISSIONER RUBIN: So what do you do?

KYLE HOOVER: What do I do? I mean, give me a scenario. That's kind of where you have to break it down. That's why a lot of this research stuff is really great for us to take a step back and look at things and say hypothetical's about stuff that you almost do need to get down to that specific example, like to your question of what do I want to do, well we need to weed through it. And that's why we almost have to wear so many hats. And that was another thing I had to kind of cut out of my speech was just how we feel like we are so part doctor, part therapist, part even animal control or code inspector for houses, part confidant in some cases, and part only safety that a child has ever known. So I guess it is tough to answer what would I do because it is what I do.

SHAWN VETERE: May I add to that?

COMMISSIONER MARTIN: Please.

SHAWN VETERE: I think that given our different roles I have more time to be able to prove some of that. I have this length of time where kids are not in the home. So if I have concerns about parents and parents being unsafe I am able, more than Kyle is, to be able to take some of that time to see is it really an unsafe situation that the parents are involved in as opposed to Kyle who is on a lot shorter time frame then I am.

KYLE HOOVER: I should also add too that it does lead back to making sure we put eyes on the child if we have those feelings too so that it does continue our involvement, because I always tell people we might be closed but it takes one phone call to change that, especially with young, vulnerable children. How do we have objective adults in their life?

COMMISSIONER MARTIN: David, does that answer your question? Commissioner Petit?

COMMISSIONER PETIT: I have two questions, one for Theresa and one for the three social workers.

Theresa, the evaluation of adherence and compliance with the different models you were showing, what have you found when you look at whether states are actually adhering to this stuff or individual caseworkers are? How do you measure whether or not people are actually doing what it is that you are prescribing or what somebody has adopted as policy?

THERESA COSTELLO: Well, the only formal review of how states are doing, really, with adherence to, for example, the ASFA requirements that I talked about would be through the CFSR process, which, as you know, is just about to start up again. So there will be a process of looking at casework practice on at least a sample of cases to see how risk decisions are made and how safety decisions are made, how safety plans are developed. So there is that piece of it that what we do from a practice point of view, what we call a "fidelity assessment" where we go in after say six months of implementation of a decision-making approach and we pull a sample of cases that we believe is representative of wherever the implementation has been, and we look at the application of the decision-making constructs to the cases, at least as they are documented in the automated system and look for sufficiency

of information collection, and then how that information is taken and translated into a decision about safety. Is that what...?

COMMISSIONER PETIT: Well generally, what is the CFSR showing? Is it showing a lot of states are in compliance? A lot of states are out of compliance? What are they showing?

THERESA COSTELLO: Well the CFSR measures, of course, have just recently been revised because we are about to start the third round. So the only results we really have go from the second round, which ended a while ago. But still challenges with recurrence. You know the number one measure of safety is repeat maltreatment, which is recurrence. So a new, substantiated report after the previous substantiated report, and there are, I would say, still many, many states that don't meet the recurrence requirement, and I don't know what the next round of reviews will show, but...

COMMISSIONER PETIT: So that leads me to the question of you social workers. What are the size of your caseloads?

KEVIN HOOVER: Well in terms of investigation I think right now I have 25 to 30, but that encompasses insuring with that 45 to 60 day completion.

COMMISSIONER PETIT: If you could rewrite it, if you could and money was no object, what would the caseload size be?

KEVIN HOOVER: One. (laughing) I mean, seriously, I think we could spend 40 hours a week on one case. Ideally, though, I think the family would get sick of us.

COMMISSIONER PETIT: What about the other two?

SHAWN VETERE: I think it is the way the caseloads are counted that you have to look at to be able to say what a caseload looks like. So I have a family that has seven children, and everything that goes into that is still counted as one case. So you can look at it as I have 12, but I also have 30 kids on my caseload in custody.

COMMISSIONER PETIT: What should it be?

SHAWN VETERE: Ten, realistically. I mean, but it should be counted a different way, is what should actually happen.

COMMISSIONER MARTIN: Commissioner Bevan?

COMMISSIONER BEVAN: I'm sorry, did I miss...how did Vermont score on CFSRs, in terms of safety?

THERESA COSTELLO: I don't know Vermont's scored.

COMMISSIONER BEVAN: Okay. My second question is I'm looking at the case of the little boy, Payton who died in February. When he was born he was dead in 5 weeks to an opiate. And my concern is that CAPTA requires that a safety plan be put in place when a child is born addicted. Do you have a safety plan in place in hospitals when a child is born addicted? And what happened in this particular case?

KYLE HOOVER: I can't speak to the specifics of that case, it wasn't assigned to me. But there is, in our policy, a provision around opiate addicted babies and having to do a written safety plan. A Plan of Safe Care, I think, is what it is referred to.

COMMISSIONER BEVAN: Right. Exactly.

KYLE HOOVER: And then we do locally, with our hospital and our Women and Children's wing. They have the same sort of language to corroborate around those cases and do additional training around making sure those were recorded.

COMMISSIONER BEVAN: Is this when children are born? Is there some sort of safe care put in place and does social work, work with the parents at the hospital?

KYLE HOOVER: If we get that report that there is an opiate addicted baby we are responding at the hospital with an assessment, collaborating with the hospital staff, yes.

COMMISSIONER MARTIN: Commissioner Rodriguez?

COMMISSIONER RODRIGUEZ: I have to say I have a lot of empathy for your role as an investigator and how difficult it is. Unlike Commissioner Horn, I haven't ever been an investigative worker but I have been a child who has been on the other side of having an investigative worker come into my house and try to assess safety, and I know that the task you are faced with is actually nearly impossible to really assess what is happening in that family when families know and professionals are there to take their children they are going to present a particular way. And so I think my question is a little bit beyond what Commissioner Petit asked, which is if you were to sort of redesign the way that an investigation happens to really be able to go in and effectively assess what is going on with a family and be able to create a safety plan, what would that look like? Sort of "sky is the limit", "money is no object" thinking about all the different entities that could potentially be involved; mental health and law enforcement. What do you think you would really need to do a good job?

KYLE HOOVER: I think it plays up on the information I just talked about, that teaming approach that the multi-disciplinary team model, but having more time and more funds where there is no question about how do we triage, like what is an acceptable wait list time for a mother who is admitting she has addiction issue? What if the trained professionals can really deal with child trauma and how do we continue to support them in the field because there is also that burn out piece there. But I think in terms of things like differential response, in terms of creating these Child Protective teams, I think we are moving into almost that arena. The "pie in the sky" idea is money and time. But I still think the framework we have is sort of the best. At least I look at we have drawn a line in the sand, and there will always be issues with where that line is drawn, but I feel okay with where we are at, but more importantly our ability to continue to evaluate where that should be. And again, that is part of this process too and why I appreciate even the question of being here this morning.

COMMISSIONER MARTIN: Commissioner Covington?

COMMISSIONER COVINGTON: My thought is the next piece after investigation, which is when we look back at a lot child fatalities what we see the first part was done pretty well but then the kids are back in the home, and what we see is over time the eyes aren't on them as well

as they should be and you see longer, extended periods of time, and the worker was there two months ago, they were there three months ago, and it gets more dangerous in that house for the child. And I'm wondering what your best recommendations would be during the long-term care plans for kids when they are left at home to keep them safe. Do you have any feelings on what minimum requirements should be for worker touch on families?

SHAWN VETERE: When they are left in the home and they are not in custody?

COMMISSIONER COVINGTON: Yeah, when they don't go to foster, they go back home.

SHAWN VETERE: I didn't hear on you that part, I'm sorry. That they were in custody and then went back home?

COMMISSIONER COVINGTON: Right or they never went to custody.

SHAWN VETERE: Okay.

COMMISSIONER COVINGTON: When the decision is made to keep them at home how much attention should they be given? How much energy needs to go in from the system on this family? I know that is a weird question, maybe, to ask.

SHAWN VETERE: I think there is some dependent factors on how they got home. Is it through a court decision? Are they part of...we have family support cases where they never left the home and we are monitoring the home and I think those cases that, Matt, you have a lot of too, and I just specifically have the custody, but I think in cases where there is court oversight and those children go home before DCF says they should be home, that happens all the time. And in that case, like the oversight has to be if the judge allows it. The judges make conditions where we can't do unannounced visits, which are really important in those kind of cases. Like you need almost weekly contact to be able to assess and insure with everybody involved not just the home. And that is impossible to do.

COMMISSIONER MARTIN: Commissioner Rubin?

COMMISSIONER RUBIN: You know, in many ways I have always learned from the child welfare system. Child welfare folks have always been out in front on terms of population health and like risk ratification, and trying different models. And in many ways in health care we are sort of catching up and trying to learn from experience. But what I have learned over time, and particularly as we do this in the medical side, is that as we focus on quality we don't necessarily think about work flow and we ask more and more of our front-line folks. And I'm looking through the documents here and intuitively structured decision making makes a lot of sense, right? But I also see the other side and I know this debate is going on in child welfare, which is that there are more check boxes, and another thing put on my plate that I have to fill out and that can sometimes reduce, and this is what happens in health care too, the time spend looking into the eyes of the person I am speaking with, right? So the flip side is a whole push around qualitative case reviews, which says, "Let's define the standards of our system, go deep on some cases and learn as a system together and try to change culture, but while reducing the demands on the front line staff." How do you play those two off of each other in terms of to what degree the tools themselves start to become a barrier to effective casework?

KEVIN HOOVER: So it is funny, even the strengths that I talked about, to include centralized intake and those tools, they started as exactly what you are talking about, another thing on my desk that I was reticent to, and kind of not practicing what I'm preaching in terms of change and not being open to it. But when I found that I could use those tools in that face-to-face communication and in that engagement and take it out of that realm of a check box that is when I realized the value in that. Now I do have to triage those too. You know, an out-of-home sexual abuse, because in Vermont we do those cases and Child Protection as well, I am not looking at a danger in safety assessment if we have had no history for those real key decision-making points, in fact, we forgo the risk assessment being complete, especially if a parent has been protective. So I think it is a balance, and it is the finding a way that a tool creates face-to-face, effecting a change, or somehow it is shown to be an engagement tool. Because there have been, in the course of my time, tools that weren't that, tools that were check boxes.

COMMISSIONER MARTIN: Thank you very much, ladies and gentlemen. We certainly did appreciate your testimony, it was very informative. At this time we are going to take a half-hour lunch break. We are going to resume at 12:55. Thank you very much.

PROCEEDING RESUMED

COMMISSIONER MARTIN: ...portion of our presentation we will be speaking with quite a few people. We are going to start with Lt. Lance Burnham from the Vermont State Police. And what I would like to do is I am not going to go through your bios. I don't know if you were here earlier, we do have your bios, and in an effort to save time we will just go straight down the line, and then after everyone has had the opportunity to testify then my fellow Commissioners may have questions of you, if you don't mind.

So Lt. Burnham, if you don't mind, sir?

LT. LANCE BURNHAM: Thank you. First of all, on behalf of the State Police we do thank you for allowing us to come here and get an opportunity to testify. In the state of Vermont I think what we have the Vermont image of being a "safe state", and a welcoming state. We unfortunately are not unlike any other state in the nation, we have our issues. We have our heroin issues, we have a severe domestic violence issue, we have a severe sexual assault issue, and we have severe assault issue in general, burglaries, larcenies, and anything like that.

But obviously we are here to talk about child abuse cases. I can speak for the Vermont State Police, we treat these cases extremely high on our priority list. In the state of Vermont, back in 2010 the Vermont Criminal Justice Training Council made it mandatory that all existing law enforcement officers attend a 10-hour domestic violence training program. That goes above and beyond the academy class, which is usually a one or two day training that specifically relates to domestic violence problem. Within that domestic violence training it also relates to sexual violence and child abuse. Every two years every Vermont law enforcement officer is required to again attend a 4-hour mandatory domestic violence training. Within these 4-hour and 8-hour training blocks there is a significant amount of time that deals with child abuse and how to report these cases, what to do in these types of cases, how a first responder is supposed to act, who they call, what are the legal ramifications for a law enforcement officer as he responds to these cases.

In 2009 we had a horrific incident that happened in the state of Vermont that led to the injunction of Special Investigation units within the state of Vermont. What that does is it made it mandatory for every county to have a specialized unit that deals with child sexual assaults, child abuse cases, and severe child abuse cases in that every law enforcement officer has the ability to assign a detective to these units. Due to manpower issues, obviously, in all law enforcement Vermont State Police being the largest agency in Vermont, we have assigned detectives to these units. One of the goals of these units is not only to actively investigate these cases, but it is also mandated to provide training to our first responding officers on how to recognize child abuse, what to do when they recognize these abuses, and again what are the legal ramifications for them to take, or if they don't take what are the actions upon them?

I was lucky enough to be part of one of these units for 4 years. I taught that class myself. I helped in generating the class and writing protocol. That class is approximately 12 hours long. We try to break it up into two day increments just so we don't overburden our officers. But again, that goes above and beyond the domestic violence cases.

In the state of Vermont, I can speak for last year, we had investigated cases in the state of Vermont to through the Special Investigation unit and we had approximately 1,300 cases that came across these units. And these detectives that are assigned to these units obviously received advanced training to include forensic interviewing trainings, child abuse cases, child fatality cases and so forth.

I think it has been very well received by our troopers. I can speak to the troopers themselves, especially the road troopers, because they are seeing these first hand. They see these, they know what they are, and we do have very strict guidelines of what we expect our troopers to do when they go to these cases.

We also know that troopers are human beings and they make mistakes, and as any officer they are going to make mistakes. Our goal is obviously not to punish but to learn from the mistakes of our fellow brothers and sisters. No one wants to be that person that makes a mistake and has a statute written after them. (laughing) So we do take this extremely seriously. I think since the advancement of this advanced domestic violence training we have seen very few, if any, cases where we haven't acted appropriately.

COMMISSIONER MARTIN: Thank you so very much, Lieutenant. Our next speaker this afternoon is Ms. Amy Torchia from the Domestic Violence and Sexual Assault network in Vermont. Thank you.

AMY TORCHIA: Thank you much for having us today and for inviting us to talk about Vermont's domestic violence communities' response to child safety. I am the children's advocacy coordinator at our state coalition, which is the Network Against Domestic and Sexual Violence, and I gave you a PowerPoint if you want to follow along.

So just a little layout of how the domestic violence programs look in Vermont. We have 14 domestic and sexual lines programs, 12 of them are domestic violence programs and nine of those have shelters, and most of our programs are dual, which means that they provide services to both domestic and sexual violence survivors. Our smallest programs have three staff, our largest one has about 15.

Another snapshot that over the last five years we have had an incredible increase of requests for services and at the same time we have lost a lot of funding, so we have lost about 20 full-time advocates across the state in the last five years. Our coalition office where I work in Montpelier is the office that provides not only technical assistance to our programs to bring them the best practices from the nation but also to give their programs voice to things like this, so we can come and talk to you about their experience as well.

I looked around for some more statistics on overlap of child fatality and domestic violence and there is really not a whole lot, and you probably know that. What I did find was Jeff Edleson from the University of Minnesota. It is not his research, but he quotes a 41% to 43% overlap, which is coming from child fatality reviews. So that is an overlap where, in a child fatality case, in 41% to 43% of the cases there was also domestic violence in the family. And we don't always know when there is domestic violence and it could be that we don't find that out until after a child fatality. But luckily, in Vermont it doesn't happen all that often. I mean, we have had a rough year, but generally we don't have a lot of domestic homicides and we don't have a lot of child fatalities, relatively speaking. I think the good news there is that adult survivors of domestic violence really are accessing safety where they can call law enforcement when they need to. They are coming to our services and they are accessing the legal system.

I did want to point out two specific cases where it did seem that there was an overlap of domestic violence and child homicide. Both of these cases were in 2013. One was actually in New Hampshire, but very close, and a father killed his nine-year-old son at a supervised visitation program. In Vermont there was a 14-year-old, Gunnar Schumacher, who was killed by his father, and both of these were murder suicides and in both cases there was domestic violence involved. We know that mostly from the media, and because there were protection orders that the moms had sought ahead of time, and some court actions as well. So I bring those up mostly because I want to be able to illustrate how our programs probably would have responded to those families had they come to us for services.

So with the domestic violence programs in our state, we are going to look at any increase in concern for risk for an adult as also an increase in risk for their child. So we know, for instance, that when a family leaves a domestic violence situation that there is a lot of increase of risk for both abuse but also for a homicide. So through our hotline, advocacy, emergency shelters and intakes, whenever we are talking to families we would normally talk to an adult first. We are going to be listening for things about weapons, threats to kill both the mom and kids, if we hear about strangulation or drugs, criminal behavior, any DCF involvement or if there is a step-parent situation. All of those things are going to indicate a higher risk for the family. Then we would encourage reports to be made to DCF if there was child abuse, either encourage the mom to do that or do that ourselves.

We spend a lot of time doing safety plans with survivors and their children. I gave you a brochure of what we hand to kids. Sometimes, if it makes sense we will give it to their parents. Also, law enforcement usually has copies of those to bring to scenes that they can give to kids, and that includes...and this is what we would have done in either one of these cases, probably, if we were talking to the mom on the hotline or had her talking with us. We would be thinking about all the places that they go and all the ways that those places could be safer for them. If they want to access the legal system and get a protection order or not, if they want to come into emergency shelter or not, and when I keep saying "or not" it is because sometimes those things really aren't the safest choice for a family and sometimes

getting a protection order is if it doesn't feel safe at all. In the cases that we just looked at, they both had protection orders at one point and they both did access the court system and it didn't help these particular situations. Neither of the moms were involved in these murder/suicides, it was the children, and it makes me think that the ultimate way to be abusive to somebody is to kill them or their kids.

We also do safety planning on outside systems so if children are at school make sure there is a protection order at the school, "Who picks up your kids? Do you have a code word for making that safe?" and on and on about accessing mental health, maybe using GALs in the court system. So that is a lot of how our programs are going to be assessing child safety is listening to moms and kids, listening to their concerns, listening to what they think their risks are, which is usually right-on, and then asking them how we can assist them in finding the kind of safety that they feel like they need.

I want to point out just a couple of things that are happening in Vermont. One is a Lethality Assessment Program. There are actually three, the slide says two but one is just starting now in Chittenden County. This is an evidence-based question survey that in a community where domestic violence and law enforcement are collaborating on this project law enforcement takes the survey out to the domestic violence scene and they would conduct these questions with the adult survivor. The goal is to identify high risk for lethality and then to offer them an advocate on the phone if they want to talk to an advocate. So there are these questions and if you answer the first three, it is an automatic call to the hotline, and then any four of the next seven. There are two questions that have children as indicators, and this is all based on research that if there is a threat to kill you or your child that is going to indicate high lethality, clearly. The second one comes a little later in the list, but if there are children in the home, it raises lethality, and second of all, if it is not the biological child of the perpetrator it also raises the lethality.

So what we are finding in our community right now, and we don't have the data yet to say the homicides have gone down, and luckily we don't have a lot of them, but it has raised awareness among those communities and law enforcement and they are looking around for kids in a different way because now they know that it is an indicator of lethality for the family. In Maryland, where this project and this particular tool was created they have seen a 34% decrease in domestic homicides in Maryland, and now they are rolling it out to hospitals and all kinds of things.

Some statewide work that we are doing is we have a rural project, which is funded by Office of Violence Against Women, which is collaboration between DCF, Family Services and the Domestic Violence Network. The purpose is to increase safety for adult survivors and their kids where there is both child abuse and domestic violence.

I just wanted to also highlight on this slide the law enforcement protocol that we created in 2004, which was the first of its kind that was collaboratively created with law enforcement, Child Protection, and the Domestic Violence. It actually turned into training the officer. He was eluding that this specifically around domestic violence and children and officers' response to kids on domestic violence calls.

The other thing that I wanted to point out is the Safe and Together model is a child protection intervention approach that looks at domestic violence and child abuse, and DCF has done training statewide on this tool now and it is a tool for DCF. They also have done

some training with districts. The rural grant that I talked about established a Domestic and Sexual Violence Unit within DCF so they consult on cases with caseworkers and social workers where there is domestic and sexual violence. So they are going to be supporting this model and the critical components are really important. They look at specifically the perpetrator's behavior and the perpetrator's harm to the child as well as the impact that behavior has on kids, and then they look at the spectrum of the protective behaviors of the non-offending parent, and they look at what that person has done to keep kids safe.

Finally, what would help us, I think, is some more research and tools to understand a little bit more about how batterers and people who perpetrate domestic violence are a risk to children. We would like to know more about, for instance, abusive head trauma and domestic violence. I couldn't find much that linked batterers to child fatalities, but I am sure that it is there, I just don't think it has been researched.

Also, links to youth suicide where there has been domestic violence in the home, because that is an emerging issue for us here in Vermont, and tools for other systems and our own system, and other systems that actually are decision-making systems, such as courts. So for instance, in the cases that I am talking about there was supervised visitation in New Hampshire that was ordered for that family and the incident happened at the supervised visitation center. So it could be that no court could have made the right choice there. They really tried to set up safety for that family and it didn't work. In other cases where survivors are asking for custody or for limited visitation because she knows there is a lethality issue for her family and she is really worried, that we create some tools for a better assessment in that area.

Thank you so much.

COMMISSIONER MARTIN: Thank you very much. Our next speaker, ladies and gentlemen, is Ms. Jacqueline Corbally. She is the Clinical Services Director for the Vermont Department of Health. Welcome.

JACQUELINE CORBALLY: Hello. I am coming before you to talk about addiction in the state of Vermont, and unfortunately this is not a happy time. Anytime you experience loss of life when there is an addiction present is not a good time. I think everybody is aware that our governor made a profound statement in his State of the State Address when he was pretty clear that Vermont has an issue with opiates. Frankly, I don't think we are different than a number of states, but for Vermont this is a huge, major issue.

For the first time since we have been keeping data our opiate admissions are surpassing alcohol admissions, and this is going back 50 years. It is something we are profoundly paying attention to. This issue has an effect on a large number of systems, families and individuals. We recognize that this is a chronic relapsing disease. We understand the complexities when we talk about addiction's impact on folks on a number of different levels.

Our system in Vermont is a Preferred Provider System, which means the folks that I oversee at the state level are clinicians around the state who are both providing patient, intensive outpatient, residential and what we would call Opiate Care Alliance (inaudible) Initiative. We have worked very hard within our Preferred Provider System to provide education to the clinicians that are out doing the work on a daily basis. We also have private clinicians, which we do not oversee, but we do have individuals out there providing services to a number of

individuals. I would say that the clinicians that I work with on a daily basis across the state were not prepared for the epidemic that they are facing. They did not go to graduate school prepared to deal with the magnitude of systems involvement that these individuals are dealing with. The folks that we work with in our Preferred Provider System work hard to really assess when individuals walk in the door looking at not only mental health and substance abuse, but also looking at trauma and the impact trauma has on the individual.

The folks that we work with in the state of Vermont understand that this is a family disease and that this is not only the individual impacts but it impacts the family and oftentimes the children that are in the homes of the individual who has been diagnosed. Part of the assessment process is to not only look at how the disease is affecting them but how is it affecting the family and what are the risks to young people in the home. So part of that assessment happens when folks enter the door, but that assessment is ongoing. The clinicians that are working with these individuals are working on a daily basis to assess the risks not only to the individual and family but also the young person in the home.

When individuals present themselves to formal treatment there is a lot of discussion around releases being signed, and as you can imagine there are those individuals who don't want to sign the releases that might need to be signed in order to have solid treatment planning. There are a number of people who are coming through the doors of the clinicians who might be involved with the Department of Child Welfare, might be involved with the Department of Corrections and they really hesitate to sign those releases for fear that their children are going to get taken into custody or they themselves are going to violate an Order of Protection or find themselves incarcerated. So this is an ongoing conversation that happens with the clinician and the individual that is sitting there in front of them.

One of the things that we recognize is that we need to do a better job at working together as a system. There is a lot of work underway. One of the positives that comes when you have an opiate epidemic or an epidemic of any magnitude is that systems really need to discuss how they are going to work together and, really, how are you going to work for the betterment of the person sitting in front of you? So currently, one of the things that is ongoing in Vermont right now is the collaboration between the Department of Children and Families and ADAPT, which is where I sit at the Department of Health.

Looking at when families present themselves for formal treatment, how do we go about working as a system, how do we get releases signed, and how do we really talk about strength-based treatment planning and really looking at the individual and the family and looking at what is best for them.

One of the pieces that is exciting about this work is that conversations are happening that didn't happen five or 10 years ago. So we are really working hard within the provider system, within the formal treatment system as well as with our other departments, and along with AHS. How do we work together and how do we really have solid planning, treatment and having conversations that folks might not want to have five or 10 years ago?

The other thing that is exciting is that we are working hard to engage and offer training around addiction to all state employees within the Agency of Human Services. That is not a small feat, as you can imagine. We are talking about thousands of individuals that will have exposure to not only understanding addictions but how do you screen, and understanding how, when you screen and get a positive screen, you make the referral and have the

conversation with the systems I was mentioning earlier? That is underway. We are hoping to begin that formal process of training within the next month, and hopefully within the next year we will have all state employees trained in addiction and understanding what addiction is, what is co-occurring, what does diagnosis look like, how do you screen and how do you refer?

We have got our work cut out for us. I will say that Vermont is a fantastic place to work when you talk about systems integration. One of the things that is exciting about Vermont is that we recognize we have an issue and people are stepping up. You have the panel before you. You have the folks behind me. We have folks that are out in the field doing the work. People do not hesitate to work together, and people have really come forward to say, "We have got an issue, we need to address it, we need to do better than what we have been doing." And so there is a level of optimism and hopefulness in the work that we are doing. We are recognizing that we have got a ladder to climb, but there is a sense of hope that we are going to be able to do that because everybody is in the same place. Individuals who live in Vermont have the right to access to treatment and services, and they have the right to have state-of-the-art services delivered to them in order to really enter a life of recovery and hope that they deserve.

One of the things that I am incredibly excited about and that the woman sitting next to me is going to talk about, I would say, without a doubt, Lund Family Center is by far one of the state-of-the-art treatment programs in the country, and we are very blessed to have them in Vermont. We look at them as a preferred provider and as a partner. When we talk about women and children, and we talk about access to services we really look at Lund to be the leader for us in our state about how those services are going to get provided.

So as we talk about the transition and as we talk about the hope it is partners like the Lund Family Center that are stepping up and working with us across the state agencies that really allow this work that we are doing to come forward. So I feel like do we have an issue around opiates? Yes. Are we going to conquer that addiction? Absolutely. Are we going to see and make sure to insure that individuals in Vermont have access to state-of-the-art services? Absolutely. And are we going to be better at the end of this? Absolutely.

COMMISSIONER MARTIN: Thank you so very much. Ms. Kim Coe? She is from Lund, as we just heard, which is a residential and community treatment program here in Vermont.

KIM COE: Thank you. I appreciate the opportunity to speak with you all today. As you said, I am the Director of the residential and community treatment programs at Lund. Lund has been around for 125 years in this community so we have a long history of working with Vermont families and always with the target population of pregnant and parenting women and their children.

So what the services are has evolved over time to meet community needs, but always, for the 125 years, that has been our focus. We are uniquely positioned to address issues of child welfare and addiction in that we are one of 15 legislatively designated parent/child centers, which serve as a hub of early childhood services in our community. So we have a licensed childcare, we have home visiting services, transitional housing, an education program, supervised visitation and reach-up services.

We are also the only residential treatment program in Vermont that serves women who are struggling with mental health and addiction issues as well as their children who come to the program with them and live in our center. Many of these women have connections to child welfare and to corrections. During their treatment episode with us they receive parent education and support, life skills education training, and health and wellness education as well as the direct treatment for their addiction.

Part of what has helped us to evolve and continue to provide innovative practice, I believe, is that we have been the recipient of two SAMHSA grants for pregnant and post-partum women so have had the benefit of working with that cohort of individuals around the country who are serving the same population. We also were in the first cohort of grantees for the Administration for Children and Families Regional Partnership grants.

So in Vermont, our regional partnership grant was designed by our entire community, who spent a lot of time talking about what was the need in our community, and then the grant we wrote was for the partnership to be primarily between Lund and the Department for Children and Families. I want to talk mostly about that project because I think that has really shifted and changed our practice in Vermont in a very positive way.

There were three components of our project. One was an assessment program, and the purpose of this program was that when child welfare was going out on an investigation where there was concern about the safety of children and concerns about addiction they could refer the family to come and reside in our program for a comprehensive assessment. So at a time when child welfare is faced with making the decision of, "I don't really know all that is going on in this family but I am concerned enough that I don't think I could leave this child here," they could come and live in our program and avoid the family being disrupted while still receiving a very comprehensive assessment. So that was a very exciting project that we had during that time.

We also had developed a Children's Play Lab. So for families that did need to be separated because of safety and protection issues, when families visited they were provided an opportunity to visit in our play lab, which is a child-centered environment where parents are not only observed and assessed but also provided with education and support. So we are taking advantage of that opportunity of the visitation to also be helping the family and strengthening the family.

The last piece of our project was to provide co-located staff in the child welfare office in Burlington, which was is our largest county in the state. We provided co-located substance abuse screeners, and their role was to go out with the investigator at the very first call to provide screening to families in their home right away and to hopefully address barriers to treatment. I began my career in child welfare and so when we were writing this proposal I was thinking, "I'm not sure how I would have done this when I worked at the department." So it was a project that we wrote with a lot of hope for what could happen and with a lot of support from the leadership and the state.

We also co-located a substance abuse clinician in the local child welfare office who would be available to provide assessments to families right away when they were screened as needing that, and be able to provide an assessment that would be helpful to all of the partners of the team.

So this was a really important piece of our work. At the end of our five-year project, the outcomes we saw were significant. We saw that in the Burlington District Office there were fewer children that needed out-of-home placement during that time, there was a decrease in maltreatment re-occurrence, parents had significantly improved timeliness to treatment, and we had improved across systems collaboration, all of which resulted in children being safer and families being healthier. At the end of that grant, what happened is that leadership from the Office of Drug and Alcohol Programs, which Jackie represents, and child welfare made a commitment to sustain this work. And they could only sustain it for one year at that time because we didn't really know where the funding was coming from, but we knew that we wanted to keep doing this work for families. So they sustained that work in the Burlington District Office, and then in the next year that work was spread to include another district office in the St. Alban's region of our state. This year we are putting four more screeners in more regions around the state.

I think that the answer to how we keep kids safer is that we all need to work together to do that. It needs to be a shared responsibility. It could never be one agency, one department; it has to be all of us. That is what has been exciting about this work is to have people say, "We are willing to look at this differently and we are willing to try something different," and we did it, and it worked.

COMMISSIONER MARTIN: Fantastic. Thank you so very much. Mr. Charlie Biss, the Director of Child Adolescent and Family Unit of the Department of Mental Health. Thank you so much, sir.

CHARLIE BISS: Thank you very much. First of all, I just want to say I have been doing this position for over 20 years and the mental health field has changed a lot during that time. We saw the ton of changes to make, but I wanted to just talk about a few.

One is that I take what the ION Report said, that mental health is essential to one's overall health and well-being. That is a very important guidepost for us to be focused on in the mental health field, and it really applies to this subject as well. I also realize that we do not have all of the needed providers to be able to really implement in that in our state.

The other piece was that over 20% of the population will have a diagnosable mental health condition in their lifetime. So when we are talking about mental health we are really talking about "us", we are not just talking about "them". And I think that is an important thing, especially as we are talking about a mental health condition being a risk factor. I agree, but there are also tons of people that have mental health conditions that are terrific parents. So I just want to kind of get to that place.

One of the other pieces that we have been collaborating with child welfare on for a long time, to the extent that over 60% of kids that are in child welfare custody are seen by our provider system, and what we do know is, and this is a cause of concern and I think focus, is that we don't serve as many young children that are in custody and that certainly is a target, and we don't serve as many of the transition-aged kids that are in custody who often could be the young parents as well. So I see that as a place for a lot of improvement and a lot of work.

In mental health, we are siloed. We have adult mental health and child mental health. I represent child mental health and people are asking me is someone from adult mental health going to come here too? And I see that as a problem. I see that what we need to be looking

at, and it is something we are looking at in Vermont right now, is called the family-based approach, an approach to work with families and their mental health and well-being and not individuals and their mental health and well-being, so to really focus on the entire family.

We are also gearing up in the state to get all of the funding that goes to children and families together in one budget and budget that out to communities for overall child and family outcomes. We have miles to go, but we are very excited about that approach. And what we are really excited about is that it is about families and family health and well-being.

That is the other point that I wanted to make, is that from a mental health lens we are looking at mental health risks and protective factors. We need to be looking at that and the well-being of the family. That usually determines the safety. It is a little different lens than just looking at safety in a vacuum, and I think that is important. We sometimes get into jags about what we are focused on in a team meeting and it is usually around some of that. The other part of working with a family is that you can get releases from families about information that needs to be shared. So oftentimes, the big barrier of mental health is confidentiality and HIPPA, but if we are actually working collaboratively with a family as a team it is usually a lot easier to get a release. There will be times, obviously, that you won't get a release.

The other part that I want to emphasize is that as a system we are mandated reporters. And as I went around to the adult world and was asking them questions about how often do they ask about individuals, you know, do they have families connected to them? It seemed like about 50% of the time they do, so it is not enough. We need to be really looking at what is a household and a family approach as opposed to just an individual approach. I just want to emphasize that one of the reasons I think we are really institutionalized into and focused on an individualized approach has been the way funding works, and I would love it sometime if there was some kind of funding system that actually funded family health and wellness, and that we were able to deliver services like that. But I would also ask you to stay tuned to Vermont and this ISF movement that might actually get closer with a lot of the services that we are going to try to blend into one contract.

So I am going to end there.

COMMISSIONER MARTIN: Thank you so very much. Commissioner Rubin has a question.

COMMISSIONER RUBIN: I'm chomping at the bit. This was terrific, all right? We have been talking about, "What does it mean to have a public health approach supporting the mission of the child protective services? What is a community-based approach?" and this was great. I'm going to take that lead from you, Charlie, because I am looking at Amy, at Kim, and Charlie specifically, but also you as well, Jacqueline.

In a population health model, distributed work flow is the key. Asking the social worker on the front line to do everything is never going to work. And so to the degree that we partner, like you guys are doing, and you co-locate substance abuse treatment or you co-locate domestic violence assessment, that is the vision. It is a community coming together and thinking about that family approach rather than the response to an incident, right?

What is it going to take, and Cindy you can answer this question too. We are thinking about recommendations that would incentivize or be permissive to do exactly what you guys are

doing here. And I thought about your comment, you were part of a grant. What are the sustainable financing mechanisms? What are the recommendations you would like this Commission to make that will make your job easier to co-locate those services across a community? And so I would welcome any of you to respond. I think, Cindy, you know a lot of child welfare financing laws so feel free to comment.

CINDY WALCOTT: Well, I think you are highlighting something that I kind of alluded to this morning and that had to do with federal financing. Right now, as you are well aware, we have all of these silo-funding streams. I do think there is interest everywhere in trying to break down some of those, but with the separate eligibility, and the separate billing requirements, and this, that, and the other thing, it makes it really difficult.

Kim talked about this co-location project that we have going on, which I would agree has just really been highly successful. That represents a collaborative between Jackie's shop, ADAPT, Lund, and ourselves, and so we are very persistent here in trying to break down those barriers, but it is not always easy because of the federal constructs with Medicaid, title IV-E, CAPTA, and et cetera, none of which really focus on the sort of prevention aspects of the work that I think we would all agree is key.

I hope that is helpful.

JACQUELINE CORBALLY: I would just like to add that one of the other pieces around when you dispense the work load and you talk about integration and working together, or when you talk about the clinical end of services, how we are based on a fee-for-service model. We also are really struggling, and I wish Senator Sanders were here, because one of the things we are really trying to bring forward congressionally is the parity between Medicaid and Medicare, which does not exist around addiction services. So we are seeing a higher number of individuals needing to access with that as the primary insurance. That particular insurance is not accepted for addiction services, and so we have a huge need for parity between Medicaid and Medicare.

AMY TORCHIA: I think one of our most successful collaborations has been between Domestic Violence and DCF Family Services. We have had this grant since 1997. That is why it is so successful. Because we know in Vermont we have to process everything here. Things take a long time to change. So we have been sitting at the table for 17 years in order to bring these two systems together and work collaboratively, and co-locate, and continue to have the conversations, and continue to train each other. So my message would be that whatever funding we get, and we are all grant-funded, we have to rewrite our grant every 18 months, every 3 years, and if the grant goes away the projects go away. So there is that much work that we have to figure out how to do without the funds. So I would say longer-lasting, sustainable things that you don't have to rewrite for every 3 years would be helpful.

CHARLIE BISS: I think we are beginning to redo our Medicaid Program that works for us a little better, and that is because we got involved in the global commitment for a program, which was really a capped Medicaid program that allows us a lot more flexibility. So that has been a beginning. You wouldn't believe. Just being able to do some of that work, how it has changed the ability not to be just producing widgets to get paid on 15 minutes increments. That is just the beginning; it is just touching the surface. Whatever you can talk about in terms of merging funding sources or paying states to achieve outcomes would be a delight for us to hear, because then we would probably be better poised to achieve those outcomes.

COMMISSIONER MARTIN: Ms. Coe?

KIM COE: I would agree that paying for outcomes is what makes sense and I won't pretend to understand all the complications behind Medicaid funding and beyond the scope of funding my own program. I do understand the restrictions around siloed funding, which we struggle with all the time.

I hope that part of your recommendations that you make is about courageous leadership because that is what it took for people to take a chance on doing something different to say, "We think this could even cost us less at the end of the day, and we know that it will be better for families so we are going to take a shot and we are going to see what happens. So I think that is a big part of this as well, is having the courage to say, "We need to look at this and do it differently."

COMMISSIONER RUBIN: Send in as much as you want on those recommendations. You guys send them to us because this is what we are thinking about.

COMMISSIONER MARTIN: Commissioner Covington.

COMMISSIONER COVINGTON: Yes, I was just going to add to that. You know, rather than leave it to us to figure out if you guys have some really substantial ideas on that please let us know. It sounds like you have thought about this pretty seriously. Vermont seems to be on the cutting edge of health care reform in general.

I was wondering if in your early experience with health care reform there may be lessons for the rest of the country. We hear in other states how people are trying to figure out how to make the Affordable Care Act work for high-risk kids.

But my other question was sort of tied to that. What about information sharing? We have heard a lot, in our other public hearings, that information sharing and the federal rules against the sharing of confidential information about families, agency to agency, has been a huge barrier. Have you addressed that, and how have you figured out how to get around it, or deal with it, or address it?

LT. LANCE BURNHAM: If you don't mind, I think specifically my role is I oversee major investigations. And when I was part of the Special Investigations Unit we worked hand-in-hand with the Department of Children and Families, the Department of Mental Health, and the Department of Health themselves. At the beginning it was a battle. It was a real battle, specifically as it related to HIPPA and all these other confidentiality issues. But I think as time has gone on that has eliminated somewhat but not fully. And I speak from my own experiences from a lot of these major crimes and sexual assaults that deal with children. Getting records from different agencies has been a challenge, even though we are working the same case. We could be in the same room and they are not allowed to share certain information. When myself, as a law enforcement officer, who is trying to put a case together there might be a piece of information here that could either up a charge, it could lower a charge, it could do anything. It has been difficult in the past. I do believe it is getting better, especially since the formation of these Special Investigations Units. When we are all together we have a multi-disciplinary action committee and we sit down and we say, "What do you bring to the table? What do you bring to the table? As law enforcement, this is what we bring

to the table." So a lot of times it is a matter of talking and sometimes it's a misunderstanding of HIPPA, or it's a misunderstanding of certain protocols of confidentiality. But I think sitting down as a multi-disciplinary agency has eliminated comfortably I would say about 80% of that problem, I would say.

JACQUELINE CORBALLY: I can say that one of the things that really trips up the addiction world is CFR 42, and I think as we are moving to integrated health care and we are really looking at health care as a whole, looking at both physical and behavioral health we, as a system, outside of just Vermont, as a country we really need to look at CFR 42.

COMMISSIONER COVINGTON: Tell us what CFR 42 is.

JACQUELINE CORBALLY: It is the confidentiality protection in federal statute that a lot of clinicians become licensed and feel that because they have CFR 42 in a lot of the funding that they get and it is tied to CFR 42 that they can't share information. And so I know that SAMHSA are really looking at as we move into a more integrated health care where does CFR 42 fit in and how does it replicate HIPPA, how does it not replicate HIPPA, and is it frankly something that we have moved beyond as we talk about best practice and clinical services.

COMMISSIONER MARTIN: Commissioner Petit?

COMMISSIONER PETIT: Yes. I have one question for Mr. Biss and a couple of questions of Lt. Burnham, just building on this question of confidentiality.

If late afternoon on Friday a government agency contacts you or a private mental health facility that is basically 100% funded by the government and a Child Protective worker calls and says, "We need to know if this parent is taking their medications. They are in a very agitated state, we are concerned about it, and we will feel better if we know. Is this person taking their medications? They are being treated through you or your surrogate." What would your reply to that because, assuming that the parent says, "No, I don't want to share any of this stuff with anybody," and you haven't been able to get that release earlier. What would you do?

CHARLIE BISS: If I didn't know...and you are also implying that I wouldn't know who this person is or that I do know.

COMMISSIONER PETIT: No, we know who the person is. We are telling you who it is. I am the Child Protective worker, the supervisor. We don't really want to take this kid out but we will take him out if necessary. I just need to know from you is the father doing what he said he was going to do.

CHARLIE BISS: Yeah, my knee jerk reaction would be I can't release that information.

COMMISSIONER PETIT: You can or can't?

CHARLIE BISS: I cannot release that information without a release. Maybe what I would offer in that case is sending out an emergency services worker to see what is going on in the family and work with the child welfare agency to see what resolution could be made.

COMMISSIONER PETIT: Then for Lt. Burnham. Lieutenant, did the State Police know any of the five cases where children were killed in 2013?

LT. LANCE BURNHAM: Yes.

COMMISSIONER PETIT: And what do you think went wrong, just generally? I mean, were there systems kinds of issues in which...no one can predict who is going to do what, but as you look at those five was there anything from a systems point of view that would have made it more likely and easier for those children to be protected?

LT. LANCE BURNHAM: That is a very loaded question. I guess what I, without speaking specifically about the cases, because they are still active and we are not allowed to, my general, overall feeling, and this is a personal feeling, is that communication needs to be shared. And I'm not saying any agency did poorly or the investigation was conducted poorly or anything like that. Because we cannot predict the future, we just don't have that ability; I don't think it does anything to Monday morning quarterback what somebody should have done or what somebody should not have done.

Not being involved with four out of those five, and I was the lead on the other, it is hard for me to really answer that question.

COMMISSIONER PETIT: I have a related question to that. Some of these individuals had a domestic violence order to restrain from approaching the family, and some individuals view it for what it is, a piece of paper unless someone is going to enforce it. How do you guys enforce domestic violence orders?

LT. LANCE BURNHAM: We have no choice, we will enforce it. We don't have a choice. Domestic violence law is we have a mandated response. This is what happened and you will be arrested. If you have committed the crime of domestic assault you will be arrested and you will more than likely be lodged at either a jail or some sort of facility. Now the protection order is the same thing. You will be arrested. The problem with that is that it is a piece of paper and there is the feeling out there by the victims that if I go get the piece of paper it is going to make my situation worse, and it is going to put me in a negative view from my abuser. We would love to be able to go to the victim and say, "We are right here, don't worry about it." But the reality is that we are not.

COMMISSIONER PETIT: You can't provide that kind of presence, can you?

LT. LANCE BURNHAM: Absolutely not. We are not immune to any other law enforcement agency. In the state of Vermont, we only have 320 Vermont State Troopers throughout the whole entire state. As of right now, we are below 300 just for manpower, and that is including the command staff all the way down to our local troopers. We are the largest agency in the state of Vermont, and we cover 80% of the population of Vermont. We just don't have the resources. It is difficult. But having said that, again, we can't predict the future, but I am very confident in saying that those investigations that were done law enforcement-wise were at a very high level, and evidence is overwhelming at times.

COMMISSIONER MARTIN: Commissioner Bevan?

COMMISSIONER BEVAN: I have two questions. We have heard across the country so far a call for flexibility, both in terms of IV-E and we have heard it also in terms of Medicaid. And everybody wants to have the flexibility to be able to pay states for the outcomes, no problem. Lots of agreement on that one. Where the disagreement comes in Washington is, one, the willingness for a state to give up an open-ended entitlement. Would you be willing to give up an open-ended entitlement for a block grant?

And the second is would you be able, as a state, to develop a baseline in order to determine and aggregate amount of money that would be given to you as a flexible pot over the say the next five years?

It is very difficult for states to come up with this baseline. I just want to know if you would be able to do it and would you have the willingness to give up an open-ended entitlement for a flexible plan?

CHARLIE BISS: Well, we have, with Medicaid. Our Medicaid, the way it is done right now it has been capped and we do not have the same growth. What did you call it?

COMMISSIONER BEVAN: An open-end entitlement. Because I heard you say "capped" but I don't think that is the same as totally...you have capped it, but is it totally an open-ended?

CHARLIE BISS: Yes.

COMMISSIONER BEVAN: You gave up an open-ended entitlement for this?

CHARLIE BISS: Yes.

COMMISSIONER BEVAN: And how are you doing with it?

CHARLIE BISS: We have renewed, so we like it.

COMMISSIONER BEVAN: So you would do the same thing for IV-E? You think you could come up with...

CHARLIE BISS: Well I don't know IV-E enough to...

COMMISSIONER BEVAN: IV-E is child welfare.

CHARLIE BISS: I know what it is; I just don't want to speak for Cindy. (laughing)

CINDY WALCOTT: Well I have been very active in child welfare finance reform over quite a long time. I say with some trepidation yes, and the trepidation for us is because we are in an upswing now with our children in custody. So that is scary. So I feel like we are particularly vulnerable now, but as I have said several times today, if we cannot move services upstream we will never get to a different place. So I feel like yes, I think we should be able to move the money around in a flexible way with an emphasis on earlier upstream.

COMMISSIONER BEVAN: You are a very innovative state. (laughing)

CINDY WALCOTT: Thank you very much.

COMMISSIONER MARTIN: Thank you very much, ladies and gentlemen; this is very informative for all of us. Is Dr. Joanne Wood in the room?

JOANNE WOOD: Thanks a lot.

COMMISSIONER MARTIN: Good afternoon, how are you? Ladies and gentlemen, after Dr. Wood testifies we will take a break. I did want to inform the Commissioners as well as the audience that the GAO Report on Child Maltreatment indicated and provided the estimate cost and benefits of collecting national data on near fatalities, and to take appropriate actions, and commissioned us to take appropriate actions and make recommendations for appropriate actions so that they don't lead to fatalities. So Dr. Joanne Wood is here today to testify about this issue and she is from the University of Pennsylvania. Dr. Wood? You can begin, and they will come in, trust me.

JOANNE WOOD: Good afternoon. I would like to thank you for the opportunity to speak to you about near fatalities. So my experience with near fatalities comes from my clinical work. I am a child abuse pediatrician at Children's Hospital of Philadelphia, so I care for many children who are admitted with severe injuries. My area of research is also focused on caring for victims of abuse with severe injuries, and then for the past five years I have participated in a near-fatality and fatality review in the city of Philadelphia.

I wanted to first start by defining what a near-fatality is. So under CAPTA a near fatality is an act that is certified by a physician, and places the child in serious or critical condition. So as a physician this is a little bit of a confusing definition because there is no medical definition of near fatality. It requires that a physician certify the child being in serious or critical condition but there is no consensus among physicians about the definition of serious or critical condition. So depending on which physician you ask and what hospital the child is brought to you are going to get different answers.

In addition, the definition requires that the physician certify that an act caused the child to be in this condition, and this is problematic because physicians, as mandated reporters, have to report when they have a suspicion or a reasonable suspicion of abuse or neglect, but they are not used to be asked to certify that a case is from abuse. I'm a child abuse pediatrician, this is what I do. I go to court and I testify. The first time I was asked to sign a form making this certification that an act caused this I got really nervous. And most of the time these kids are going to general hospitals. They may be seen by ER doctors or ICU doctors who have never seen a case of abuse before. They may not have heard of CAPTA or know what a near fatality is. So I am concerned that this definition may result in under-certification.

In 2011, when the GAO Report was released, there were 32 states that had defined near fatality, and those definitions vary from state to state. There were 19 states that had started collecting data about near fatalities. Some of them are merely collecting how many near fatalities, whereas others were reflecting more detailed information.

Since that time, about three additional states have defined near fatalities and begun collecting information. So in 2011 it was 19 and I think three more since then. Not all of them are publicly releasing that data, and some of those states are just purely numbers whereas some it is much more detailed information.

I wanted to walk through a couple of case examples just to highlight the differences and the definitions across the states and how this can impact who is considered a near fatality.

The first case is a three-year-old little girl who comes into the emergency department with severe belly trauma. She has been kicked and punched in the belly and she is bleeding into her belly. And she is bleeding so much that she goes into shock, and goes into cardiac arrest in the emergency department. Luckily for her, CPR is started, she is resuscitated, and she makes it to the operating room. She has a really long hospital stay but ultimately does well and goes home...well, not home, but to foster care. So this case, I think we could all agree, is clearly a near fatality. This is a child who could have died, probably should have died. If she had lived a few minutes further from the hospital with a different trauma surgeon on that night, she may not have made it.

The second case is a little different, though. It is an 18-month-old boy who came in with heroine ingestion. No one actually said he ingested heroine, but mom found him unresponsive in bed and couldn't wake him up and she called 9-1-1. When EMS got there, they found him sleepy. They couldn't wake him up. He wasn't breathing well. He had pinpoint pupils. They noticed some drug paraphernalia, so they appropriately thought about opiates, like heroine, gave him the antidote, which is naloxone and then he woke up. By the time he got to the emergency department, he actually looked good. He wasn't seriously sick. And so although he could have died, and we have certainly seen many deaths from heroine ingestion, this is a child who at the time he was evaluated by a physician was not in serious or critical condition.

The third and last case is a two-month-old baby boy who came into the hospital for evaluation and management of traumatic brain injury. Luckily for him, he didn't have too severe of an injury and by the time it was detected, however, it was old. So he had brain injuries from both bleeding around his brain and injuries to his brain tissue as well as some fractures, but he didn't actually need any ICU level care, he didn't even need any medical management in the hospital. The unfortunate part is he does have clear brain injury, and there is concern about what his development is going to be long-term.

So were those three cases near fatalities? Well, it is going to depend on which state you live in and what doctor you ask. So I am going to walk through a couple of sample states. If we start with Indiana, the definition is, "A situation where a child has been admitted to the intensive care unit and has been placed on a ventilator because of injuries from abuse and neglect." So if we think about our three cases, the little girl with the belly trauma who coded and went into cardiac arrest in the ER is clearly a near-fatality, but neither our 18-month-old with heroine ingestion who could have died or the two-month-old who is going to have long-term brain injury from head trauma would be considered a near fatality.

If we move on to California, it is a very similar definition. Again it is, "A severe injury and requires that the child have received critical care for at least 24 hours." So if we think back to our three cases, the little girl with the belly trauma, again, she is going to be considered a near fatality, but neither our 18-month-old with heroine nor our two-month-old with head trauma will be.

My home state of Pennsylvania. So initially, our definition was the same as CAPTA. It was, "An act that is certified by a physician that places the child in serious or critical condition." We started reviewing all near fatalities and fatalities in 2009, and one of the early recommendations from the near fatality reviews was actually to change that definition. So

that actually happened in 2014, and now the definition is, "A serious or critical condition as certified by a physician where the child is subject of a report," and that is very different, because you ask the physician two separate things; was there report, yes, and is this child in serious or critical condition. And you are not asking them to certify, then, an act that caused that child to be in severe or critical condition. The other thing that happened is all of the near fatality reviews in Pennsylvania, or at least in Philadelphia, is that there was a recognition that different physicians were certifying different cases as near fatalities. So it was recommended that we have a convening, which we did in Philadelphia. The child abuse doctors got together and we came to some sort of consensus about what we would certify. So if these cases were in Pennsylvania, the three-year-old with massive abdominal trauma would certainly be a near fatality. If you ask me, the 18-month-old with heroine ingestion would also be. Some of my colleagues might disagree, and at least in the city of Philadelphia, we have decided that all children with abusive head trauma are near fatalities, but that might differ in different counties.

The final state that I wanted to highlight was New Jersey. So in New Jersey a near fatality is a serious or critical condition certified by a physician, again, that suffers permanent or physical impairment, life threatening, or probability of death within the foreseeable future. So if we go through our cases, the belly trauma, yes, heroine ingestion, no, two-month-old with head trauma, permanent injury, so yes.

So why I wanted to go through these is you can really see these are all three kids who are very similar to fatalities. These kids could have died. And in some states, they would be near fatalities, and in some states, they wouldn't. So this definition can be very confusing and cause a lot of variation across the states.

So now that we are all clear on what near fatalities are, I want to talk a little bit about what do we know about them? So the first thing we want to know is how common are they? I'm not aware of any national estimates for near fatalities, based on child welfare data. So as I mentioned, 19 states...or now 22 states are collecting data on near fatalities. Some of them are publicly releasing that. If we look at individual states, they report rates of .9 to 2.7 near fatalities per 100,000 children, which compares to the .9 to 6.3 fatalities per 100,000. So the rates are similar. Some states, depending on their near fatality definitions, have more fatalities than near fatalities where others have more near fatalities than fatalities. So it really depends on their definitions.

The other place we can go to get information about the numbers is from the serious injury data from hospital data. So if we look nationally, there are about 6.4 hospitalizations per 100,000 children per year for severe injuries. We looked specifically at smaller grouped children, so this is how many kids get hospitalized under the age of one, that highest risk group that we are really worried about for fatalities. For each child who dies under that age of one there is over 10 children who are hospitalized with severe injuries. So that suggests that really near fatalities are much more common than fatalities. And you can make an argument that not all those children requiring hospitalization are really that severe in the near fatalities, but if we look even at the abusive head trauma group and these are kids with head injuries admitted to the hospital, for each one who dies there is more than five who are hospitalized.

So what else do we know about near fatalities? How are they similar to fatalities? So I would propose that they are really similar because in many cases these are same types of active

abuse and these are kids who through luck or circumstances had a near fatal rather than a fatal injury. If we look at what we know from the child welfare data, they are, in fact, similar in their child characteristics, the perpetrator characteristics as well as the risk factors.

This graph is showing you the age distribution. This is from Pennsylvania, because again we don't have any national child welfare data on near fatalities so I had to pick some states. So the graph shows you in blue the percentage of kids who are under the age of four. So if you look first at the fatalities you can see that the vast majority of fatalities are under the age of four. Next comes the near fatalities. Again, the vast majority are under the age of four. And then if you move over and look at all child maltreatments, and that is the general population of children who are substantiated victims of abuse, you can see it is a much different age distribution. The under four make up a small group; you have lots of the 5- to 9-year olds and a lot of the older kids. So really looking at the age, the near fatalities are similar to the fatalities.

Another way of looking at this is using that hospital data that I had mentioned. So these two graphs show the age distribution for children who die from physical abuse or are admitted to the hospital. So I guess that one is on your left. And then on your right are the incidents of hospitalizations due to serious physical abuse. And the numbers, the incidents, the rate is much higher for the hospitalizations, but you can see those distributions look almost identical. We are talking about a very similar population of kids.

Another similarity is gender. So again, we are looking first at fatalities. In blue is boys. You can see there is a majority of boys among our fatalities in the child welfare system as well as in the near-fatalities, but then if you look at all child maltreatment cases substantiated, you can see there is actually a predominance of females. So again, our near fatalities and fatalities are similar.

There is also this data from California looking at the perpetrator relationships. So first, we have fatalities and then near fatalities, and if you look in both our near fatalities and our fatalities, overwhelmingly moms and dads, followed by mom's significant others, and then other relatives. So really, if we think about the child characteristics, the perpetrator characteristics, they are really the same group of kids.

There is a little bit of data available from child welfare on risk factors. This is from Pennsylvania showing what percentage of fatalities and near fatalities had a previous history, a documented history, a criminal history, substance abuse, and domestic violence. And again, they are in the similar range for fatalities and near fatalities.

Finally, why should we study near fatalities if we want to prevent fatalities? So this is something, as you mentioned, the GAO Report recommended, and I think the reason for that is because they are such a similar group of kids, and by looking at them we can hope to understand the fatalities. And I am going to argue they are more common than fatalities so we can greatly increase our numbers, and numbers are important. So if we want to look at the incidents of fatalities and figure out how are we doing? If we have a state that only has a few fatalities, and you could have an increase one year that is just a blip, it is a random blip on the radar, if we want to be able to more accurately figure out how we are doing by increasing our numbers and having a broader base we can more accurately trend how we are doing. We can look and see did that prevention program make a difference? It also gives us a lot more power to be able to look at risk factors. So when we think about fatalities the risk

factors for a child who is going to die of neglect are very different than the risk factors, or some of them, from the child who is going to die of abusive head trauma. And so by having near fatalities plus fatalities, looking at not just those kids who died of abusive head trauma but also those kids who could have died, we have more kids to look at so we can better understand what are the risk factors and how can we identify those kids and separate them out from all the other kids in the child welfare system? How do we know who we really need to focus on?

Finally, I think at the local level there is a real role for near fatality reviews combined with fatality reviews to help identify policy changes and practice changes at the local level. So how can we study them? There is state near fatality data that I am going to talk about first, and then the serious injury data from abuse.

So as we mentioned, near fatality data is collected by over 20 states. Some of the states are reporting data publicly, some of that is aggregate, so if you go to the Colorado website you can look at how many near fatalities they had and you can also look at what was the age breakdown, gender and different demographic characteristics. Pennsylvania is also reporting that data. Some states are just reporting the numbers; other states are reporting the actual case histories. So Pennsylvania you can read the actual report and investigation summary of it from each near fatality and fatality.

There is the benefit of looking at the numbers, but there is also, I think, a richness to some of the case examples, and so I am going to talk about the Pennsylvania data. Pennsylvania had a particularly egregious death in Philadelphia of a girl who died while under the care of child protective services, and there were some changes that happened. And one of those was Act 33, which established that there must be near fatality and fatality reviews for every child in which there is a report to child protective services. And there is a local team, so I am a member of the team in Philadelphia. Within 31 days of a report being made in which it is certified as a near fatality or fatality, that team must be convened, and it must be convened if it is substantiated or if they haven't made a decision about the case yet. That local team gets together and we have representation from law enforcement, child protective services, the school district, the hospitals, behavioral health, domestic violence services and a whole range of experts and we review, in detail, the case.

The goal of that is to really look at how did child protective services and other county agencies do in serving that child? What were the strengths? What were the deficiencies? As well, they look at what kind of practice and policy changes could be made to improve and prevent additional near fatalities and fatalities? Within 90 days we write a report that goes to the state. The state has 45 days to respond. That report includes recommendations, and those recommendations go to the Commissioner of child protective services in Philadelphia and they also go to the Mayor. And the Commissioner has to assign people or departments to work on implementing those recommendations. Then once a year we get a report back of what they have changed, what they haven't changed, and what they are going to do to make the changes that have to be done soon.

In Pennsylvania, over 400 cases have been reviewed to date. In Philadelphia County alone we are tough in our review and we have made over 140 recommendations. The majority of those have actually been implemented, and just a couple of examples, like I said, one of them was changing the state definition. There were also, early on, a lot of things that we noticed just happening over and over. One of them was that sometimes the workers weren't

understanding the medical complexity of the cases. They didn't understand, especially for those complex medical needs kids, or the kids with injuries. So one of the things that changed was the availability and the protocols for consulting nurses that are on staff at child protective services.

There was also a lot of lack of communication between CPS and law enforcement, so there were Memorandums of Understanding that were drawn up between the different groups as well as protocols put into place to facilitate communication. There is, as I said, 140 recommendations, so there is a lot that has been changed. I don't know that there is data to say that has prevented abuse and neglect in Philadelphia, but what I can tell you is that having sat on that committee for five years we would see, initially, same problems over, and over, and over. Things that were just missed opportunities. And now I have seen some of those recommendations be implemented and we are not seeing those problems anymore, which isn't to say that we still don't have problems, and we still see near fatalities and fatalities, but we have seen, at least anecdote, change.

So there is, I think, a richness in the near fatality data and a lot of opportunities to use it. There are some challenges. So as I said, there is no national data. NCANDS doesn't have a near fatality field, so none of our national data can tell us how many kids have severe injuries, how many have near fatalities. There is a lot of variation in the state definitions, as I discussed. So if you want to be able to look at how is one state doing compared to another and what is happening, you can't really compare across states at all, so that variation prevents you from being able to aggregate and combine the numbers from states. Not all states are collecting data, so we are up to over 20, but not all of them, and not all of them are reporting it, or are reporting it in the same way. There is a lack of core data elements across the states. So one state might be collecting this type of information from their near fatalities and another state is collecting different information. They might define those data variables differently so it is hard to use that data together to understand more about near fatalities. Some of this data that is reported is heavily redacted. So if you look at Pennsylvania's reports, a lot of the information is blacked out, so there is rich information there but to protect confidentiality you can't actually read it or use it.

A couple of recommendations about things that we might be able to do to improve this. One, I think it could come from the Children's Bureau, being clarification of the definition of near fatality at the federal level. I think there are two areas; one is the clarification of the role of the physician, and this removing or just changing the phrasing of the requirement of a physician to certify an act. And I think I would suggest Pennsylvania as one possible language for doing that where it is two different things, that a report was made and that the child is in serious or critical condition. I think there also needs to be some guidance to physicians and providers on the definition of serious or critical condition, and there could be development of tools and tip sheets. Kentucky has a tip sheet that they use for their workers for specific questions that guide the physicians through making this determination. Another thing that would need to happen is collection and reporting of near fatality data by all states, and that would include not just the numbers but if we really want to be able to get at and look at the risk factors then we need to have common data that is collected for all states to look at these kids, who are the perpetrators, what were the risk factors, and what were the families' circumstances?

I would suggest that this be coordinated with the child death reviews, so in Philadelphia, as I said, we sit there and we review these near fatalities and fatalities, we collect a lot of

information, and separately there is a child death review that happens, and they collect information and there is not really any talking. So I think having some overlap and coordinating elements with the child death reviews as well as better communication between the different groups. I would also recommend supporting states in conducting near fatality and fatality reviews so they really want to do this to improve their practice. That's what they said to the GAO, but I think it is a tough thing to do. In Philadelphia, unfortunately, as a county we have a lot of cases. We meet almost every other Friday for two to three cases. We have gotten pretty good at doing this. But some localities where they are not as busy aren't as familiar with this and it is a hard thing to get set up and running properly.

So I think one of the main ways we can look at near fatalities is through that child welfare data, but the other opportunity I think we can look at is the serious injury from abuse data, so looking at your medical data. There are a lot of sources available. This is actually my area of research. One of them is hospital administrative data, medical claims data, and research networks data. So there are national databases that capture children who are admitted to the hospital and they have a diagnoses piece in them, so you can look at what is the rate of children hospitalized with this type of injury from abuse across the U.S.

One of the real advantages to this data is it is based on a medical diagnosis. We all know, looking at NCANDS data that you can't compare one state to another because there is too many differences in the definitions, in the protocols and the practices that affect how many cases they have. And it is also hard to look at child welfare data for trends across time because there are changes in protocol and practice. But if you look at hospital data, which is based on whether or not the doctor diagnosed abuse, which isn't really subject to all those changes in policy and practice, you can look at trends across time and you can also look, potentially, across localities. So if you want to see if a prevention program worked that might be one way to look at it.

This is just an example of how that data has been used. So this is from the kids database, which is a national database and is a state, federal and corporate private partnership supported by AHRQ [Agency for Healthcare Research and Quality] out of the federal government. What they did is they looked at hospital admissions with a diagnosis of serious physical abuse from 1997 to 2009. This is during a time when the NCANDS shows that overall the number of substantiated cases of abuse and neglect is going down, but what the hospital data showed is that hospitalizations for severe injuries are actually going up a little bit, and so it provides a different way of looking at and monitoring how we are doing.

There are challenges to the hospital medical data as well. It is primarily limited to physical abuse so it is not going to tell us that much about those kids with neglect, which do make up a significant portion of fatalities and near fatalities. Some hospitals are better at using diagnosis codes and putting in the record who is a victim of abuse than others, so there is going to be some variation across hospitals. None of these databases, whether it is the trauma databases or the hospital administrative databases, are focused on child abuse and neglect, so you can get some information but if you really want to look at all those things that we want to know about, like who was caring for the child, you are not going to get that from these databases.

There are some things I think we could do to maybe improve this. One would be development and validation of standardized definitions for abuse-related medical codes, and this is something that the CDC has been working on, so they published diagnosis-related codes for

fatal and non-fatal abusive head trauma and have used that to trend those rates across time. So that is something that could potentially be expanded to other areas of child abuse and neglect.

There also needs to be improvement of the utilization of diagnosis codes, and that will be something that will be important as the U.S. prepares to switch from ICD-9 to ICD-10.

Then I think there does need to be a collection and reporting of more data elements that are specific to child abuse and neglect. So we can't just rely on what is standard collected, and whether that will be enriching the data that is already there and building off of those data systems or whether we need some child maltreatment and child abuse specific data collection systems.

In summary, I think that the study of near fatalities really can help us understand fatalities and how to prevent them, because in many ways they are the same kids who died, they just were lucky or through circumstances. There is a couple of opportunities to use data both from the child welfare system as well as the medical system to do that, but I think there is some changes we need to have in order for us to optimally use the data.

Thank you.

COMMISSIONER MARTIN: Doctor, thank you so very, very much. That was very informative and very information-packed.

COMMISSIONER AYOUB: I just want to clarify you said that 20 states collect data, but how many states have a review team like you do?

JOANNE WOOD: So that...I don't know the exact number. Not as many have it. I know Colorado has one, Pennsylvania has one, so there are at least a handful of states that have them. What cases they review also differs. In Pennsylvania any near fatality that is substantiated or is still in progress, we review. In some states it is limited to cases that were previously involved in the child welfare system. I can see if I can get an exact number, but it is not all the states that are collecting near fatality information.

COMMISSIONER AYOUB: Do you think there is resistance from the other states, or they just don't have the resources? And finally, it sounded like you have thought about having a little separation between Near Fatality Review and the already existing child fatality review teams. So is there a reason not to merge those?

JOANNE WOOD: On the GAO Report, more than half the states said that they wanted more assistance and reviewing and collecting data on near fatalities in order to help inform their prevention efforts. I don't know that there is resistance on the part of the states. It is a big task, and it requires participation from experts from a lot of different fields to get together, it requires administrative support to occur. So I do think that there is something that states may require our support in doing, but I think it is something that there is definite interest in doing.

The second part of the question was about the child death review teams and the near fatality review teams. It is not that I think there should be separation; I think that they do have slightly different aims. The near fatality review, which also reviews fatalities is really focused

on looking at the county agencies, how they did, what they could have done differently and making recommendations. That, I think, can be very helpful in forming practice. One of the limitations is that it doesn't have any power over non-county agencies. So we often find that sometimes, unfortunately, it is the doctors who need some changes to be made to the practice and we try to make recommendations. Or maybe it is a different system, but we don't have any power there, so that is one limitation. But I think the child death reviews and the near fatality reviews are happening in parallel, and there is not communication, and I think there is some duplication of effort, and I think there should be more coordination as well. There is such rich data that is collected in the child death reviews that if we were collecting similar information from the near fatality reviews then we could put it together and look at it together. So I think not having them be siloed.

COMMISSIONER MARTIN: Commissioner Petit?

COMMISSIONER PETIT: Thank you very much, Dr. Wood that was just very informative. Two questions. One is on this point that was just being made about conducting them jointly, I mean, the same panel or with additional people doing the near fatalities versus fatalities.

If I recall, they are about the same number of near fatalities as fatalities. The only area that I got a little confused by was when you are doing head trauma and you showed about a 10 to 1 difference. But overall, am I not correct what you showed was the near fatalities are about equal?

JOANNE WOOD: If you look at the child welfare data that is available for a handful of states, yes. If you look at the medical data and sort of maybe use a broader definition of near fatality then there is more of those compared to the fatalities.

COMMISSIONER PETIT: But I think the point is, right now, the federal spending and the state spending in support of all this is a very modest sum. So even though you are talking about doubling something it is a very small number to start with. So I can imagine the price tag on this would be particularly high nationally.

The second question is on this redacting question of the near fatality reviews. The confidentiality issue is one that we have been discussing a lot, and there are some pros and cons to it. From my particular point of view, when the time comes for us to really push on this I would relax the confidentiality in the fatality cases where there is a fatality. The child is dead, the parents in prison and et cetera. What are we shielding? Who are we protecting?

But in the near fatalities, and you noted that there is some limitation with the review of the data, and some are redacted. What would you modify or would you leave it exactly the same? Would you change it in some fashion?

JOANNE WOOD: Right and it is exactly what happens in Pennsylvania. The seeing committee, the near fatality review, actually reviews all the near fatalities as well as all the fatalities with the same protocol, but separately there is the child death review that happens. Pennsylvania does post the reports. The near fatalities are much more heavily redacted than the fatalities for the reasons that you suggested. Do you think that there is a need to protect confidentiality? If we were able to, rather than just having those reports, actually extract the data from those reports and then we could better use it without linking it to an individual child.

COMMISSIONER PETIT: But you could retain the confidentiality except create an exemption when it is being used by researchers for some purpose.

JOANNE WOOD: Yes.

COMMISSIONER PETIT: So you could still shield it from the public.

JOANNE WOOD: Yes.

COMMISSIONER MARTIN: Commissioner Covington?

COMMISSIONER COVINGTON: I have a quick question, which is finding these cases is a lot harder than finding fatalities, is what we hear from states. Recommendations on how you find them if you were doing reviews, identifying so you know about them.

JOANNE WOOD: In Pennsylvania, the way it works is if you call in a report they ask you if this is a near. In the medical profession if the child isn't getting medical care then you are asked if this is a near fatality. Like I said, there was a lot of problems initially about doctors not wanting to certify or being uncomfortable on what is a near fatality. So in Philadelphia if they ask the on-call ER doctor and it is their first shift ever and they get an answer they are not quite sure about they call one of the child abuse doctors. In Philadelphia they are fairly aggressive in asking and then following up, but it is standard that you get asked if this is a near fatality and then you are asked to certify it, and you don't have to certify it in writing. So it is a proactive identification of cases.

COMMISSIONER COVINGTON: I think your summary...I have never seen it done before. I hope you publish it. Maybe you have and I haven't seen it. The comparisons between the near fatal and the fatal, it is sort of what I was getting to earlier today which is I don't think they are that different and I think your data shows that they really aren't. So when we think about the numbers of fatalities and everyone talks about the fact that it is even an undercount at 3,000, if you start multiplying that by 10 you are looking at a whole lot of kids that are really, really hurt. I love the fact that you said they are lucky. It really is, to me, almost what it is. I just think that the point we have to keep our mind around is that there is a lot more kids out there that are suffering serious injuries and near fatalities, they are just lucky they didn't die from these.

JOANNE WOOD: I showed the abusive head trauma, the five to one ratio for non-fatal versus fatal, I think it is important to remember the majority of victims of abusive head trauma have long-term consequences. So even though these aren't kids who died these may be kids who aren't going to walk, aren't going to talk, they may have severe disabilities. So I think of severe injuries and I think just focusing on the fact that they got aggressive medical care and didn't die doesn't make a difference in what happened to them and how we can prevent it.

COMMISSIONER MARTIN: Thank you. Commissioner Rodriguez, and then we will just go down the line.

COMMISSIONER RODRIGUEZ: I wanted to echo that. I thank you very much for your presentation because I think you made a really compelling argument that actually these are

cases that we should be treating and looking at the same way. I think probably as medical technology advances we will have more and more near fatalities.

My question is on the near fatality reviews I hear the goal of extracting some of the systemic issues, but how do those reviews then factor since you have a living child who is still the subject of the review into the actual case itself. Obviously there is much more on the line, in terms of what happens next and are those cases expedited? How quickly do they happen? Who is at the table?

JOANNE WOOD: My primary experience is with Philadelphia, so in Pennsylvania I can tell you how it happens.

The severe injuries actually get assigned what is called an MDT team and they are actually a little bit higher trained and more experienced in taking care of these severely injured children. The near fatality review or fatality review has to happen within 30 days so at the meeting, although under law child protective services can't chair the meeting they have to be there. So DHS or child protective services presents the case. At the table is the ongoing investigation worker who can give the team an update about what is happening to the child now.

Also, if there was a prior history they bring in all the investigative teams, all the service agencies so if there was an agency that they contracted with they all come so we can ask them questions and get all the information. At the table you have physicians, you have child welfare experts, mental health experts, domestic violence experts, and so there is an ongoing dialog with the caseworker and the team as well as you have child protective services leadership there, and there are recommendations for, "I am really worried about the domestic violence dynamic in this case," or "Have you thought about the trauma to this older child who witnessed this? Has she gotten behavioral mental health assessment? I am going to recommend this agency." So there is an ongoing dialog between the groups and recommendations for the management of that case right then.

COMMISSIONER RODRIGUEZ: So really it has parallel goals, there is one to extract the systemic issues but then one to deal with the specifics of that case moving forward?

JOANNE WOOD: Yes. So I think the official goals are more focused on the strengths and deficiencies then making recommendations for systemic. But in practice it serves a dual purpose.

COMMISSIONER BEVAN: Thank you so much for testimony. I really appreciate it. I have been trying to walk your recommendations up to the federal level, because I am really into trying to get it. Take my notes and write it down so then in the future when we get a report I can write down where the funding stream is. And since I don't know the medical side, when you talked about development and validation of a standardized definition for abuse and neglect is that from a hospital and the administrative data sets and where they could fund? It's not from CAPTA and the little minimum.

JOANNE WOOD: Right. The hospitals assign diagnosis codes and in order to use all this hospital data we need to be able to have agreed-upon, standardized definitions of how we are specifically using those codes to identify these kids. That is something that I know the CDC has been working on. They did that with abusive head trauma, both fatal and non-fatal cases.

So I think that is something that would be coming from the research and whether that is NIH funding research to help develop and validate those sort of codes, it hasn't typically been a priority in terms of research funding.

COMMISSIONER BEVAN: Is that the injury surveillance funding from CDC? Is that what you are talking about?

JOANNE WOOD: No.

COMMISSIONER RUBIN: Thanks, Dr. Wood. A couple of questions and one being what potentially you have here at the near fatalities is an ability to standardize some way of surveillance, because of all the challenge and the subjectivity.

Should hospitals be required, whether you choose on a basis of ICD-9 codes and age group or on the basis of hospitals or emergency departments that actually file a child abuse and neglect report, every year to provide a basic file with the discharge diagnosis, zip code of residence, and just some basic demography and ICD-9 codes so in some ways we can actually have a more objective assessment of trends nationwide?

JOANNE WOOD: I think, since you said, "Should they be required?" that some hospitals already do voluntarily provide that so you can get the national estimates from kids' database. You can get from local hospitals information that is often available to researchers. I think rather than focus on having them required to provide that I would be more interested in improving the quality of the data that they provide, so the quality on the diagnosis codes.

If you are going to ask me my recommendations for hospitals I would also be more interested in having more of a focus on standardized evaluations for child abuse and neglect. So unfortunately, know that doctors frequently miss cases of abuse, miss diagnosis of abuse, and kids go home and come back in with severe injuries or dead. So my first focus for hospitals would actually be on improving the diagnosis and detection rather than on the (inaudible, other person talking).

COMMISSIONER RUBIN: I will add that with the meaningful use requirements we are required in some ways to ask questions about child abuse and neglect, though I'm not sure if people do it routinely. But now that all hospitals and ERs are pretty much like health records made in private offices aren't there may be an opportunity to actually expect, as part of meaningful use, some basic downloads of injuries, right?

JOANNE WOOD: Yes. And depending on if the hospital is situated in a specific community it could potentially be information that could be useful to the local child protective services agency to get a different monitor of how well they are doing.

COMMISSIONER MARTIN: Thank you. Commissioner Horn, do you have a question? Thank you so very much. Again, your testimony has been very helpful for giving us some information, particularly on the whole issue of how near fatalities and fatalities kind of work hand in hand. So on behalf of all of us, thank you so very much.

JOANNE WOOD: Thank you.

COMMISSIONER MARTIN: Ladies and gentlemen, we will clap because if you don't know Commissioner Rubin is her colleague, and so we have been hearing about their work. But ladies and gentlemen, we are going to take a 15-minute break. Thank you so much.

PROCEEDING RESUMED

COMMISSIONER MARTIN: Good afternoon, ladies and gentlemen. We were a couple of minutes early so I wanted to give everyone an opportunity to really stretch their legs and stand up and get a glass of water or a cup of coffee. But I would like to get started this afternoon with our last panel for the day, or our next panel for the day. And what we are going to do now is switch just a little bit and start talking about the current understanding of public health infrastructure and how it would need to change in order to enhance prevention of child maltreatment fatalities in Vermont.

So now we are really talk about preventive issues, if we can. And our first speaker this afternoon is Dr. Holmes. Dr. Holmes is the Director of Maternal and Child Health Division of the Vermont Department of Health. So Dr. Holmes? Thank you so very much for coming this afternoon.

DR. HOLMES: Well thank you for this opportunity and we always like the last panel of the day slot.

COMMISSIONER MARTIN: That's okay; we are still energized, so go ahead.

DR. HOLMES: Well I'm going to try to limit my remarks. This is a really great opportunity, I really appreciate it, and it's also a really big topic. So I'll try to hit on some high points in Vermont around prevention and then talk a bit at the end about where we are with our federal funding in Vermont, and what we want to do when that federal funding runs out.

So the first thing I'm not sure everyone knows, I certainly didn't and I'm a pediatrician by training and I came to my job in 2010, and I have learned a lot about what maternal and child health means, so it actually has a federal definition. Then in Vermont my division oversees the women, infants, and children's supplemental nutrition program. We do an enormous amount with school health. We try to be the outreach arm of our Medicaid agency through early periodic screening diagnosis and treatment. We have the entire Children's Special Health Needs Division, including a child development clinic, and we work very hard to apply for and maintain federal funding around home visiting, preventive reproductive health, domestic and sexual violence prevention, childhood injury prevention and we have now dived into linking action for the unmet needs in child health, which is SAMHSA funding. That's our most recent exciting foray into the prevention of and working with kids with social, emotional and health concerns.

What I wanted to talk about today is just a few examples. We are very steeped in the Bright Futures guidelines in Vermont, the authors of the Preventive Service Guideline for Children are all Vermonters, and we believe it is sort of the cornerstone of the conversation about preventive efforts in children. I want to touch on home visiting. I heard from Sara and some of the planners that you know a lot about that, but I can't help myself, because we have quite a story growing here in Vermont about that preventive strategy. We are lucky enough to be launching Help Me Grow, which is a platform I look forward to telling you about. And then I know earlier you heard about integrated family services and I wanted to bet a little more

specific with you about how we are adopting the strengthening families framework across the agency and all the departments that work with children to have a common language and that, I think, is going to prevent maltreatment.

Okay. There is our friend Bright Futures. For those that don't know, it's a set of principles, strategies, and tools that are theory-based and evidence-driven. It can't call itself "evidence-based" because it's not; it's evidence-driven and systems-oriented. So what we do in Vermont with this is this is our EPSDT requirement for kids on Medicaid, and what is fun about that is then it drives the quality of preventive services for all of Vermont's children. So we have done about 10 years of outreach to our primary care practices that see children to make sure everybody knows about the guidelines and is doing their very best to adhere to them. That is a whole talk in itself, but I just wanted to hit upon that we believe that the medical home is a great place to look at maltreatment prevention and fatalities.

This is the side I love to share, and maybe not for this group, but for other as a reminder that health is a great entry point. And when I say "health" I mean, preventive health care. And these are the national bar graph. I actually have the Vermont ones, but I was very challenged by the cut and paste, and Vermont actually does better than this, so nationally, 90% of kids get preventive health care and that EPSDT visit is the Bright Futures I described, and that's about 56%, and 36% of kids in WIC, and then it goes down from there. In Vermont, we have higher percentage of kids in early care, but 1% of kids really head start, and a couple of percentage in early intervention and so the graphic here and the visual I hope you see is that it is an incredible opportunity to impact the lives of children by connecting to the medical home.

I will not tell you too much, but in the Affordable Care Act and the Maternal, Infant and Early Childhood home visiting. We picked the Nurse/Family Partnership as our only funded program. We had existing home visiting that was terrific but it wasn't evidence-based and we took the responsibility of bringing that into our Health Department because of the rest of home visiting in Vermont is actually under the Department for Children and Families, which is another place. We have now partnered with them and we were very lucky that the Pew Center for the States identified Vermont as a kind of state on the move for home visiting, and so we have had a 2½ year alliance where they funded an interesting mechanism, the Vermont Business Round Table to then convene the group of state leaders and home visitors across the state in a monthly way so that we could head toward a common vision of what we were going to do with our multiple models. Most recently, that too was a statute, followed by a rule, and now we have a manual. So we have a lot to tell you about home visiting, and I would happy to talk about it more in the questions.

Then we got an Early Learning Challenge Race to the Top grant, which is also extraordinarily exciting from my perspective because most states that get Race to the Top money don't bring health to that table. And with that small foot in the door, we were able to write to Home Visiting and this money, Race to the Top, is bringing in parents as teachers and MESH, which is a maternal sustained home visiting program for women that are not in their first pregnancies, because the Nurse/Family Partnership, as you may know, is you have to be in your first pregnancy. So I'm really looking forward to this blending.

Then we also are funding Strengthening Families, bringing that framework to some of our early care programs through the Race to the Top money, and that is also the funding source to bring a universal, developmental screening platform to Vermont Healthy Grow. And I had

to throw in, because I'm excited about it, we also are bringing back Nurse Consultation to our early care programs and I really believe that system will be firmly rooted in injury prevention.

Okay. Strengthening families, I think most folks know this. This is a framework around five protective factors that families need in order to really begin in the child maltreatment arena, and it is from our colleagues at the Center for the Study of Social Policy in California. These five factors unify all the work that we do, and I didn't really want to overstate it but when we are meeting across our agency of Human Services and trying to integrate we absolutely all know that we are all working towards something on this list. So what we have decided is that we will measure families' perception of their factors prior to connection to our services and then after. Then at the very basic data collection we will be able to say that we could move people and families along the continuum of feeling connected, feeling resilient, understanding their child's development, knowing how to get concrete supports and then really deeply connected to the social/emotional piece.

And this is exactly aligned with Help Me Grow, so again, in the interest of time, Help Me Grow is this umbrella for coordinating early childhood services and what it started to do in Connecticut in the '90s is not what it has ended up being. It was created to find kids who are not developing normally, and what the system found, and now we are the beneficiary of 20 years of experience, is that it was a place where families could connect about the social/emotional health of their children. And it really wasn't just about kids who weren't developing normally it was families identifying where they needed to build protective factors. So as much as I wanted this platform 10 years ago in Vermont I'm glad that we now have the benefit of 20 years of experience. I think we are the 25th state.

Here we are, we have MIECHV funding, we have title-V, I think you all know that is that incredible core block grant funding from Maternal and Child Health Programs that comes from our President Roosevelt. I absolutely love that back in the 30s he and others believed that the health of the society would be impacted by supporting women and children. We now have early learning money and we have lunch money. So there it all is and as you well know from all the work we all do, all of this except title-V will go away and then we are in that unfortunate place where we know something helped. Because we are, at the Health Department, extremely data driven, and once we know we've made an impact, doubling back our efforts and figuring out how the state of Vermont will fund it has a rich, not very successful history. So I loved the opportunity to talk today and look forward to hearing my fellow panelists. This commitment to primary prevention sounds so basic, but the medical home is primed and ready to support children and families, but what we need to do is to include the support of adults in the child's medical home. With the innovation here we are right on the brink of understanding, which is kids are often not exhibiting true pathology yet. When you are a pediatrician or a child health provider and you are in the office with a family you know the mom is depressed or struggling with a substance abuse problem, but you are trained in child health and you don't have the adequate resources or really the kind of authority to step into the support services for the mom or the dad.

So we are chipping away at very small pieces of this, and home visiting is helping us, so we now know that child health providers can be screening moms for depression and that is an allowable service. I just want to build on that. I think it is very dreamy, but it is what I know for sure.

A national conversation is how on earth are we going to pay? This is an incredible investment the federal government is making in home visiting and we are seeing success and I am determined to articulate that success in a way that it is a no-brainer for our state to continue to fund it.

Then strengthening families is the one that needs more fleshing out, but I just know that when people say they want to integrate and then they don't, and for decades we have been talking about what does true integration look like, this framework is the first time I felt like everyone who works for children and families in Vermont sees themselves in that pursuit.

So I will stop there.

COMMISSIONER MARTIN: Thank you so very much, Dr. Holmes. Ms. Tanzman is the Assistant Director of the Vermont Blueprint for Health.

BETH TANZMAN: Thank you for the opportunity to be able to be here with you all day and the opportunity to learn together. I have certainly been learning a tremendous amount today. The Blueprint for Health is Vermont's patient-centered medical home statewide initiative, just to put some context there.

What I have been asked to do today is to help explain a little bit about Vermont's Medicaid Program and how we use our Medicaid plan to support the health services infrastructure that can be deployed to help prevent child abuse, neglect and fatalities but also child maltreatment. I want to talk about the impact of patient centered medical homes and what we are doing in Vermont on this area of child health and wellness and provide a little bit of examples of another way we are using the Medicaid Program to respond to our epidemic of opioid addiction and how this also relates to child and family health and child maltreatment.

A little bit about a study that the Blueprint for Health has been recently commissioned to do by our legislature on investigating the interaction between first childhood experiences and population health, and to bring forth recommendations about that, and then a few ideas and recommendations of what we could be looking for at the federal level.

This is a graphic describing Vermont's global commitment to health, the 11-15 Medicaid Demonstration Waiver. About Medicaid, we famously say, "If you've seen one state Medicaid plan you've seen one state Medicaid plan." (laughing) In Vermont, we have had an aggressive history of pursuing greater flexibility within the Medicaid Program and this demonstration waiver, which began in 2005 has recently been renewed to carry us right through 2018 where then Vermont is working to transition into a single-payer system, Green Mountain Care. So we see this demonstration waiver as supporting our transition to a more rationally funded health system.

The basic approach here is like a bargain with the devil. We agree to set an upper payment limit trend with centers for Medicaid and Medicare services, and to live within that. If we exceed that waiver spending limit cap, that upper line, we, Vermont, are on the hook for it. If we are able to, the second level that we look at is something called our Actuarially Certified Limit. This is very complicated, but essentially it is based on our history of Medicaid spending and projecting forward to what it is that, if all things stay the same and we maintain the status quo, what are we expected to spend? Then we, in Vermont, work to actually go below that Actuarially Certified Limit and those funds, that difference between the waiver

spending limit and the actuarially certified limit, we can invest flexibly in programs that are not traditionally supported by Medicaid to expand health insurance and to do these other key functions. A lot of what we have been talking about here and the examples that you have been hearing are things that are funded through what we call those MCO savings.

To be just a little bit technical about it, what the global commitment waiver actually does is establish the state of Vermont as a managed Medicaid authority. That function is typically carved out to private or not-for-profit companies and states and not done directly by state government. We are unusual in that. We are so small it probably doesn't make sense to have a layer of separate MCO administration.

As I mentioned, it allows us to use the Medicaid Program for four key areas that are not traditionally covered. We can increase the rate of insurance for previously uninsured populations so we can expand Medicaid insurance eligibility. We can increase and create new health services that support underinsured, uninsured or Medicaid beneficiaries. We can invest in public health approaches to health care. The final category that we work with is to support the formation and maintenance of public and private partnerships in health care, so as to look beyond just the public sector.

Our overall goals are to, of course, increase health access for the population and to build these public health approaches. We do a lot of piloting, we do some significant piloting of developing other approaches to paying for services besides fee-for-service. It helps us enhance coordination of care across providers. For examples I'm going to talk about the Blueprint for Health, which you heard about, and Lund Family Service is doing co-located addictions and maternal health people specialists working with our Department of Children and Family Services. These are all examples of things we can do.

Finally, we are aiming to control the growth of cost in the program, because frankly our health care budgets in states, combined with our corrections budgets will bankrupt us all and we won't have money to do the important upstream services that we have all been focusing on.

Just a little kind of stat, beginning from federal fiscal year 2006 through the end of December 2013 Vermont spent \$11.8 billion less than the actuarially certified limit, which allowed us to invest, and it was almost 15%, in other flexible, innovative services. So it has worked.

One example or approach of this is our Patient Centered Medical Home initiative in Vermont called the Blueprint for Health. We chose to focus on primary care, and that includes pediatric for a couple of key reasons. One, of course, is the cost growth in management of chronic conditions is high and primary care is best situated to help better manage chronic conditions, but the second reason of equal importance is that primary care is also well situated to help prevent chronic conditions and to provide effective and appropriate preventative care. So it is also an area in the health care system that is relatively under-resourced compared to other areas of care. So there was a consistent decision to invest in that and to use national guidelines. What we did was adapt the Patient Centered Medical Home principals that are produced by all of the major academies of medicine. We use the National Council of Quality Assurance standards that breathe life into these guidelines, and what we do is two important payment reforms based on that. We have a statutory framework that now requires all insurers in Vermont, including commercial and Medicaid, and they must pay primary care providers who meet these standards more money. It is a per-member, per-

month payment, it is a payment for quality and transformation. We base it on the national standards. All of our primary care practices are re-scored every 3 years. These standards evolve and then they are increasingly raising the bar for care. The providers get a very small payment, actually. It is one of the smallest in the nation for patients in medical home projects. It is only about \$1.50 to \$2.50 per member, per month. However, it has driven a huge amount of change in our system. But it is fundamentally designed to incent ongoing iterative improvement towards a more proactive approach to care. If I were to try to describe it in a way that relates to the conversation we are having now it would be so that practices would be resources to know, "You know what? That family just missed a well-baby child checkup. We are at 3 months and we haven't seen him, let's have someone call them and go out and bring that family in." for example.

The second kind of payment reform that we do with this besides the payments for meeting the higher standards is the development of a community health team. This is a multi-disciplinary team of nurses, social workers, health coaches, and diabetes educators that are paid for jointly by all of the payers, Vermont's commercial and public payers, and they are embedded in the primary care and pediatric practices statewide. What they do is expand the reach of our medical providers to do population health, to do outreach and advanced work, to do complex care coordination around families or individuals who need more of that. It is a utility that is supported by all payers. This staff is bought and paid for. They do not bill any fee for service and no one pays a co-pay or add any barrier to actually accessing them. The teams are multi-disciplinary and they are functionally integrated into all of our primary care practice settings, including our pediatric practice settings. They are scaled and sized based on the number of patients that are supported in each of the practices, and they are a core resource that is available for people really based on need. I, being a science fiction fan, refer to them often as sort of like the Star Trek Enterprise because they can go where none of the other payment systems go because they don't have to bill for what they are doing. They are the glue of a community health system for the general population. In other words, they are not targeted to just high-risk people, or people's severe mental illness and et cetera. They are a general health approach.

So where are we right now in terms of our progress in the Blueprint? This is a graph that shows where we are in terms of the program participation. We are up to now a little over 122 primary care practices. Our Meet the Patient Center Medical Homes fully participate in the Blueprint. We think there are about 140 primary care practices in Vermont so we are at near universal penetration. Those primary care practice homes are serving collectively a little over 500,000 Vermonters. Our population is 640,000 and we have over 125 full-time equivalent community health team staff. These multi-disciplinary teams are deployed in the practice settings.

We also developed a clinical registry that is part of what the primary practices use, and all of the Building Bright Futures' recommendations are built right into that clinical registry.

In the Pediatric practices we find that the community health team staff are often more specialized and expert in working with families. This is a workforce that I think could be considered available to help identify at-risk families for child abuse or neglect fatalities and also to rapidly intervene based on those identifications.

So how is it working? I think this is important in health care systems. We need to know that things are, in fact, paying off. We conducted a matched comparison sample of our 2012 data

that had close to 100,000 children in it. We compared the results of both commercially insured and Medicaid insured beneficiaries who were receiving services in a patient center medical home community health team environment against a population who are receiving services in primary care as usual in Vermont, in other words not a medical home or community health team. The blue graph or the Blueprint folks, the folks receiving care in a patient center medical home and the brick color is the comparison sample. I happen to be showing you here this slide of what we see in Medicaid expenditures for children age one through 17, and I can report, I think, some significant and interesting findings and trends. The first is that the group of kids seen by the Blueprint practices used less inpatient time, but they also saw more professional outpatient visits.

We think this is a good sign in terms of people and kids getting access to the kinds of services they may need and using less of something like inpatient care. We also saw statistically significant less use of pharmacy, which we think is a very positive result for children. Then very interestingly, they used more of something that we call "Special Medicaid Services", and what those services are, are the types supports that Medicaid uniquely funds different from any other commercial insurance. So they used more school-based services, they had more access to transportation, more of these integrated family services, and the types of things that we have been hearing about through the day. What this is telling is this is again among Medicaid beneficiaries in Vermont so they have the exact same benefit but the Blueprint Community Health Team, that patient centered medical home community health team environment is more successful in linking kids to those services than were primary care practices as usual.

My next slide is really too much data, but let me just say this. This is taking the full expenditure patterns that we had for Blueprint versus non-Blueprint statewide and comparing them to the matched comparison group and looking at the return on investment. Obviously, much of what we have been talking about today needs new funding and so we have to find ways of developing these return on investment arguments and driving down health care costs in order to support the kinds of investments that I think we would all agree are needed. In Vermont, in 2012, our commercial plans across the adult and pediatric population invested just under \$6 million in additional payments to providers for meeting the patient centered medical home services and the community health teams and they saved over \$93 million that year over the matched comparison sample. The results from Medicaid were not quite as dramatic, but they were extremely sound. Medicaid invested just under \$3 million at \$2.8 million in patient centered medical home community health team payments and saved close to \$6 million over the investment. And this is just in one year. So what we can demonstrate is that we have improved health care patterns, we have reduced medical expenditures, we have better linkage of a population to non-medical support services that are important, and I didn't review them, but we had similar or higher rates of recommended assessments, including things like well-child visits, adolescent well visits and so forth.

Well, Sally Borden is going to talk a little bit about our opioid treatment initiative and how we have used Medicaid funding to support additional staff into the community health teams. I just got the two-minute warning so I'm going to breeze by that and maybe we can do it a little bit in a Q&A study.

I guess what I would like to do is go to my final sort of discussion/recommendations, which are from a health system point of view. Recommendations that would help align our federal policies to exchange timely information among providers would be extremely helpful. Let me

be concrete, you heard mentioned earlier that addictions treatment information under 42CFR is not part of health system recommendations. If you want to have integrated health services you are going to need integrated information systems. We actually had three of our largest federally qualified health centers stop sending any information into our health information exchange because of the inability of the systems to be able to adequately sequester the addictions treatment information. So let me be clear again, that meant that literally the health information for some 80,000 people was not in an exchange because of these issues around the small group. This is relevant to us because addiction and substance abuse is one of the risk factors that we would look for. So if you are surveying any large data system you are looking to be able to produce reports that help identify risk, and substance abuse is information we need. Obviously, we have to have universal access to health care, and that includes parity for conditions that are not traditionally supported in the same way. I can't say enough about the importance of really moving addictions and mental health treatment to be on par with health services and frankly assuring that whole populations are covered. In states where we have not seen the Medicaid expansion it breaks my heart to think about what is happening to populations and the opportunities that we are missing to do things that we know work.

I was very interested in the previous presenter's discussion about how can we start to use what I would call "big data", in other words taking not only health care data but information. I had a wonderful conversation recently with our local police chief and he says, "We have a ton of information as we go through our day and they record it into a data system that could very much help identify patterns that could be analyzing, understood and then target resources like community health teams or others to intervene.

Obviously, we need more evidence around what are the most effective interventions. I know my legislators will be asking when I bring forward our recommendations for ACES. They are going to say, "Well Beth, what treatments actually work?"

I would encourage us to do as much as we can to align related initiatives. The discussion about whether we should focus on only childhood fatalities or near fatalities is an example from a health system point of view and a Medicaid system point of view. The larger the public health bucket can be the easier it is for us to think about what are the actual things that impact lots of things and not just some.

In listening to you I also was thinking a lot about in mental health areas and our zero suicide. It is a very similar kind of set of dynamics where it's actually not a large number of people who do it, but, in fact, they have a lot of contact with health systems. So there are many public health intercept points and helping to align these is useful because there is only so many reform activities that we, at the state level, can undertake at once.

Thank you.

COMMISSIONER MARTIN: Thank you so much. Ms. Borden is the Executive Director of KidSafe, which is a collaborative program for children and recovering mothers.

SALLY BORDEN: Thank you very much. I appreciate the opportunity to talk with you today, and I have been asked to speak about kind of a small project that implements some of the ideas that you have heard before me.

CHARMS is a multi-disciplinary team that coordinates care for pregnant and post-partum mothers with a history of opiate dependence and their babies. You have heard a lot about the risks associated with opiate addiction and the impact on children, so I will talk a little bit about this little project that we have that has done some remarkable things.

One of the unique things about CHARM is that we are not a program within one agency. The team is comprised of people from various agencies and disciplines that come together to do this work. Our focus is obviously on a high-risk population, one which comes with myriad challenges of long-term substance abuse. Without access to substance abuse treatment and the supports for the mothers, which really does take a coordinated and collaborative approach to the fact that infants are at very high risk for abuse, neglect and of course for fatality.

Our goal is to improve the health and safety outcomes of the babies born to women with a history of opiate dependence. We do that by coordinating the medical care but also all of the other services involved; substance abuse treatment, child safety, and various support services. You heard from Kim Coe from the Lund Center earlier, and they are an integral part of our team. Certainly, health care is part of our team.

I would like to take just a moment to clarify use of language. I won't be referring to opiate addicted babies because addiction really is a terminology that includes actively drug seeking, so I will be using the term "opiate exposed" or "opiate dependent". So again, we are small, we are Vermont, and so we serve about 200 patients a year. It is a small model but we feel it is a promising prevention model.

The key elements of our approach are first of all that pregnancy is an opportunity for change, just like we talked about that health care, and health care access provides an opportunity to change. Oftentimes moms are motivated to access health care and substance abuse treatment in a way that they have not otherwise been motivated to do at the time that they are pregnant. Although this is really an intervention with moms it is an opportunity for some targeted prevention of negative outcomes for the infant, even fatality. It is a high-risk population because the moms didn't become an opiate user or addict overnight with no other stressors in their lives. So we are talking about a population that without appropriate and targeted services, coordinated services and treatment for their addiction they would be at high risk for child maltreatment and again for child fatalities. So early access to prenatal care and substance abuse treatment are key. Early child welfare involvement and coordinated approaches with child welfare, assessment and development of plans of safe care prior to birth or at the time of birth, all of those are really important aspects of the collaboration and the information sharing, which I will talk about how we have gotten to the place of being able to share some information.

Just a little bit of background about opiate abuse nationally. A recent study that was published in the Journal for Substance Abuse Treatment showed that admissions of pregnant women reporting prescription opioid abuse had increased markedly, as you can see. While the proportion of pregnant admissions has remained relatively stable. Another interesting thing about that study, and there are lots of interesting things in that study, is the admissions for opioids as the primary substance of abuse also increased significantly from about 1% to 19%. So it really is reflecting the critical nature of the opiates and what we call "the opiate crisis" across our country, and certainly here in Vermont. Vermont has the second highest rate of admissions to state-funded substance abuse treatment programs in the United States. We

actually think that is not just a reflection of a higher level of substance abuse in our state but actually that we have made treatment so accessible, which reflects well. But we do have a high rate.

Also, the vast majority of opiate-dependent pregnant women are in treatment, and 4 out of 5 opioid-exposed infants were born to women in treatment. That is different, again, than your national numbers. Nationally, about a third of pregnant women reporting any prescription opioid abuse at substance abuse treatment admission received medication-assisted therapy. Despite the fact that is, of course, a standard of care for pregnant women. So I think we have certainly tried to make treatment as accessible as possible and we do this early intervention. And in this case we really believe it is a prevention.

Results and healthy outcomes. Medication-assisted treatment with Methadone or Buprenorphine is the standard of care both for the mother and for the health of the fetus. We are talking about treatment and supports for pregnant and parenting mom because it is initially linked to the health and safety of the baby. We are talking about a parent population with a very complex presentation and need of supports. We shouldn't, by the way, be having, I think, a debate about whether pregnant women should have access to medication-assisted treatment. That is the standard of care, but again, nationally only about a third of pregnant women who abuse opioids are on medication-assisted treatment and often, simply because they don't have access to that treatment, and that creates a risk for the fetus. So the health of the newborn is clearly linked to the health and safety of the mom. A healthy mother who is stable in treatment and not continuing to abuse drugs is, of course, better able to safely care for her infant.

So with that background I'll just talk a little bit about CHARM, the CHARM team. One of our team members actually came up with our lovely acronym, Children and Recovering Mothers. We had a little competition and that was the winner. I will run through, very quickly, who the project partners are and how it works.

Our primary hospital here in Burlington, which is the largest hospital in Vermont and has the largest catchment area and has a high-risk obstetrics clinic, and they provide the intensive prenatal care, initiation on Medicaid-assisted treatment, and provide the prescriptions for that treatment and the follow-up. Then we have a wonderful neonatology program, which I will talk about a little bit more. But they provide prenatal consultations with the mothers, they provide the neonatal abstinence syndrome scoring assessment, and then the infant care and treatment with developmental assessments at somewhere between a year and 18 months. Each of these, and I won't go through each thing, come to the team with a collaborative role. The initial point of entry is up in the high risk OB clinic, so they are also getting the releases of information that I will talk about later. We have set up a process and a case flow that works pretty well, but when we diagram it, it has so many arrows every single way that it is really hard to read so I didn't put it up there.

But there is a case flow that kind of makes sense. Our neonatologists keep the record of the releases of information and so on. Our community-based substance abuse and mental health agency or designated agency provides most of the Medication-assisted treatment, although other primary care providers do as well, and especially with the expansion of our Opiate Care Alliance, or "Hub and Spoke". They have different names for it. Beth referred to it in one of her sites as the "Hub and Spoke" Model.

Our child welfare department is certainly an integral part of the team. We are sitting around the same table talking about these cases and working together to come up with safety plans for each of them. Public health and maternal child health is at the table from a few of the different areas around Vermont. Public Health Substance Abuse is our ADAPT, which is the state opiate authority and they implement the alliance for opiate addiction.

The social work from the hospitals, home health agency, home visiting services, and that is what you've heard a lot about. A critical community-based substance abuse treatment and social services, and that would be Lund that provides the residential care for pregnant women and also moms and babies.

Department of Corrections provides health care for incarcerated women, Medicaid, and then a community-based organization, and that is me. I facilitate the teams, so I have been contracted to come in and get everybody together and figure out our working documents and to mediate the disagreements, if you will, as they come up.

We have come to some key elements, which are a shared philosophy, and this is really foundational and this did not happen overnight, I can tell you. This took a while, but really coming to improving care and supports for mothers is the most important factor in helping to insure health and safe infants. With people coming at this table from so many different perspectives, that is huge. It looks pretty simple when I put it up there but coming to that was a process.

Also, coming to the realization that shared information really does improve child safety and health outcomes. So we have got to figure out how to share that information or we can't do this. We developed a Memorandum of Understanding, which you have a copy of, that provides a framework for sharing the information and the coordinated services. That framework includes the Memorandum of Understanding, which is an overarching agreement among the heads of all the agencies at the table. It took us about two years of meeting, and I won't say anything bad about attorneys because I know some of you there. But those attorneys made us work for that MOU, and we came to the table a lot and a lot of hashing out language and all of that, and privacy officers from different organizations, but together we did persevere and crafted the MOU and the release of information, and basically it just says that we will work together in the best interests of these women and babies. When they sign the Release of Information we share information. We reached that agreement when we all came to the conclusion that sharing information was in these women's best interest and that, in fact, it would be wrong to not share the information. That would be a disservice to these women and certainly to their children.

The release itself was a pretty standard authorization to release medical and other information. It doesn't allow re-release of the information. One unique thing is that it does allow DCF and Child Welfare to re-release the information to the courts, if need be.

The last tool that is up there that we use is a multi-disciplinary team. So we are impaneled under Vermont law as a multi-disciplinary team, and you have heard reference to those teams earlier. It does limit our information sharing specifically to child safety under the same guidelines that would pertain to DCF. So we can only use that provision...well, first of all, we only use it when a mom hasn't signed the Consent to Release Information and there is a specific concern about child safety, and it certainly doesn't pertain to most of her pregnancy.

I will just very quickly run through the prenatal care. The comprehensive assessment initially is that point of entry primarily, although sometimes women are identified if they are already in medication-assisted treatment, usually methadone but sometimes Buprenorphine. Then they get pregnant, then they are identified there, and then they are referred over to the high risk obstetric clinic. Sometimes they receive their OB care from a private provider but then they are referred over to the neonatologist for a prenatal consultation. So they can come into this project any one of different ways, whatever works best. The other aspects of that are the enhanced prenatal care, substance abuse counseling, which is required for everyone who is receiving MAT, we have the residential program, which is awesome for a small number of those moms and babies, case management and referrals, getting them on WIC, getting them set up with home visiting and other social support services.

I would like to take a moment to talk about one of the most important aspects of this project, is that neonatology and anti-natal visit. The reason it is so important is because engaging these moms is critical to the success of the project, and certainly to the health and safety of the babies. So we try and have one or two of the anti-natal visits addressing her fears, addressing her reticence to come forward, and engaging her in establishing some level of trust is critical. Because we know that continuing the prenatal care and continuing the treatment is very, very important. So that anti-natal visit is important.

I wanted to draw your attention to Our Cure Notebook, which is a notebook that was developed by moms. The Child Protection aspect of this is that the team sits with child welfare mandated reporters, who make reports when they are concerned. But the most unique thing is a policy shift that came about as a result of the work of this team that allows for child safety intervention to begin approximately one month before the anticipated due date of the baby. You heard earlier about assessments, and so Policy 51 allows for that assessment to be conducted when there is information about use during the last trimester of the pregnancy or there is a positive screen for the baby.

The assessment is conducted when there is a threat to the child's health or safety, or where there is information about substance use. What that does, and is really innovative, is that allows time for family engagement prior to the birth, it allows for the plan of safe care prior to the birth, and it is really a child maltreatment prevention. What we find at the team is that it allows for the identification of a family when things aren't going well. So what it has really done is enable us to prevent high-risk situations, and we've seen a reduction in the number of emergency pick up orders at the hospital, "Yikes, here's a baby. Nobody knew it was coming, and it's a very high risk situation." We can plan for that. If an out-of-home care placement needs to be planned for that can happen in advance. So just very quickly, there is birth and post-natal care again doing that same kind of planning, continuing that after-the-birth of the baby.

I'm going to just quickly do our case review. It focuses on all of the pregnant patients due in a month. So we meet monthly...I should have said that. We focus on the highest risk, pregnant patients due, high-risk prenatal patients, new pregnant patients, new babies, and other high-risk post-partum patients. We talk about those each month and we focus on our key indicators, which are included in there, and plans are developed for each of those. So again, our outcomes are very positive; more pregnant women in treatment earlier, fewer premature births, fewer small birth weight infants, and DCF policy change allows that plan of safe care to happen as a prevention tool, so fewer emergency custodies and improved collaboration equals safer babies. We do have lower hospital lengths of stay for the treated infants.

There are a number of challenges. I will just suffice it to say that they are essentially the same challenges that you have heard, collaboration, you know, is ongoing work. These are patients who need a high level of support. We are very hopeful that as a result of the recent child tragedies here in Vermont that we won't see that pendulum swing the other way because that would result in women being reluctant to come into care and into treatment, and perhaps have a more negative effect.

So with that I will conclude, and hold for questions.

COMMISSIONER MARTIN: Very well. Thank you so very much. Our last presenter today is Ms. Sally Fogerty. She is the Director of Children's Safety Network.

SALLY FOGERTY: Good afternoon, and it is nice to be, I guess, the last speaker because I'm what's between you and leaving, (laughing) and maybe having a glass of wine or whatever.

I need to just clarify that I am newly retired from Children's Safety Network. It is my second retirement so I will say that I spent many years in the Commonwealth of Massachusetts in the Public Health Department and my background started many years before that, actually, as a neonatal nurse. And so my involvement, actually, in looking at child maltreatment and prevention actually started when I was a neonatal nurse and was first exposed, back in the '60s, to women and to families that were struggling. And I, from that standpoint, learned that there is a lot we can prevent and that prevention really works. And so what I would like to do is sort of move forward and share with you a little bit about what I've learned, a little bit about what I know and then I'm going to share some recommendations, some that I put on my slides and some that I haven't, and I have realized, as I've gotten older, I feel I have the right, maybe, to say things I might not have said when I was in my 40s.

The only thing I will share, other than that, is right before this I went to the ladies room and ran into two women who are from Yarmouth, Massachusetts, which is where I live. They are here because they are being trained on how to garden. And they are going to take an exam, because they have spent all these hours, for two or three days, and for weeks learning about how to raise flowers. And they said, "Oh, and you are here for the Garden Club and you're not part of our Garden Club?" they said, "No, I'm here to help us raise children because, you know, I love flowers, but children are what are going to make the difference."

So I just want to share that. I really think we have a lot of work to do because we can spend that many hours, and get that much excitement people around raising flowers? Boy, we got the wrong message. Because it should be around raising kids.

With that, I think you should think about fatalities and near misses. You are looking at the tip of the iceberg. The very tip of the iceberg. I think what you are doing is wonderful. I am glad there is a Commission. I really think, though, we really need to look at, overall, how do we create the environment that is going to really make sure our kids are safe? How are we going to look at all of those children that are below the water? Because if we can save them and make it safer for them we are going to reduce those fatalities. That is what I have learned over the last 6 years particularly, working in injury and violence prevention, is if we look broadly and we implement some strategies, if you think about motor vehicle crashes, we have reduced them, but we have reduced because a lot of people wear seat belts. So by reducing

and by doing broad strategies we have reduced the deaths, and we have reduced the near deaths in our motor vehicles. I think that is what you are really charged with doing.

George Albee, who was a psychologist and, actually, I think he is in Vermont for a period of time, always said, "No epidemic has ever been resolved by treatment of an affected individual." We are dedicating our funds, and I think we need to dedicate our funds. And we need to have all the services there so we can work with those families and those children who need it. So we need to keep all of those services. We need to understand that. But we also need to go upstream. We need to go to where we think we can make the difference. We need to change the paradigm, and you are doing that. We are doing that. We are beginning to build that continuum of prevention. We are beginning to say it's not just the individual we need to change, but it is the community. We need to look at what can we do in a community. How do we get people like these women, and the Garden Club all excited so what they are going to do is look at what we can change in our communities to make it safer for kids. We need to find the right balance to doing that. We need to move upstream.

As Gloria Steinem said in 2002, "We are standing on the bank of the river. We are rescuing people." Think about that for children. We are rescuing children. They're drowning, they're dying, but we haven't gone to the head of the river to keep them from falling in. That's what I think we really need to do. We need to work, and I know you have received information around the CDC program on essentials for childhood. This is a program that looks at creating those relationships and environments which are safe, which are stable, and which are nurturing. Three key elements. We heard from Dr. Holmes about strengthening families, which is doing the same thing and which is putting those little pieces in place that will create safe, stable, nurturing relationships and environments. All our children deserve that.

I think we need to keep using a public health approach. We need to understand surveillance. We are collecting child death data? We need to collect surveillance data and we need to use that to understand and to target our interventions. We need to make sure that everything we do is data driven. We need to focus on population and community-based strategies as well as those that influence individuals. We need to identify risk, protective factors, and resiliency, and how they interplay. I think the biggest paradigm shift and the most positive one that we have made is we have begun to look at those protective factors. We have begun to look at assets. We need to look at what makes the difference, not just those little risk factors. Not just what was wrong with that one family.

I sat here today and I listened to the caseworkers. I listened to what they said. We're sending them on almost an impossible task. We are saying, "Go in, assess, and make it all better. Take the child, but make it better." Every one of those cases, to me, is a failed case of the system, not the public welfare system, but of our system. We are all responsible. We've all failed those parents. And by failing those parents we have failed those kids. I think it is our responsibility as a society to figure out how to resolve that. We need to understand where the biological, the environmental and social factors fit in and then we need to use the right social marketing. How do we help people understand this? What got those women in that garden club raising those flowers? How do we change what we are saying so they get excited?

In 2009, I was involved in undertaking an environmental scan, which was funded by the CDC Foundation with funds from the Doris Duke Foundation to see what was happening in all of the Departments of Health around child maltreatment in the nation. We received responses from all 51 states, and what we found is that 82% of the public health departments actually agreed

that child maltreatment prevention was an important part of their work. 69% said they were involved in it. But when we dug a little deeper what we found is turf issues, "Well, we're involved but you know it really belongs to somebody else." "We don't quite all talk the same language." We found that 37% of the states had moved forward to make sure that public health language, making sure they were at the table around this, was put into law, and they felt that is what got them to the table. I don't think it is two separate issues.

Public health is health and safety. It is looking at it in the broad way, looking at it from a data-driven standpoint. Public welfare wants the same thing. They want children to be safe. They want children to be healthy. It is the two professions looking at it may be slightly differently. We have heard today about how they have been brought together in Vermont. I'm sure you have heard it in other areas. To me, that is what we need to do. How do we keep working on that? We also asked public health, "What do you think the top five roles are you should play?" And they were very clear, that they should be making referrals to external resources. They didn't need to recreate them, but they should be making referrals. We saw, again from Dr. Holmes, the range of programs within MCH. I'm going to show that again. Ideal place for early identification. Maybe even some brief interventions and then referrals.

The public health can identify and target those at-risk populations. They work with them all the time. They are there. They also say they can communicate best practices, funding and training. They can build capacity for child maltreatment efforts within the state public health agency that can support the work in the other agencies. And they can conduct surveillance, and that is what they are good at. They collect data. They know what to do with the data. We have got child death review. I think every state should be funded for child death review. Some have money, some don't have very much money, and some of them have no money. We need to make sure that every state has child death review teams. I think it should extend to near misses as well. That is what is going to help us understand what is happening.

This is the array of public health services. Kids are there. Families are there. I think it is important for us to look at how do we make the best use of all of those services? How do we help those services to know, "You are involved in child maltreatment prevention. The WIC Program, you are involved in it. You are seeing parents. You are nurturing parents. You are providing food and nutrition education." Many of them are doing Safe Sleep now. They can do Shaken Baby. But you know what? They see kids. How do we increase the communication between programs like that and our child welfare services? If the child is within child welfare do they communicate? Can they communicate? We have got confidentiality on the table. I think I heard you might be looking at that tomorrow maybe. Can they talk about or do they know if I am WIC nutritionist I am seeing Billy's mother on a regular basis. Do I know that there are issues around substance use? Do I know maybe the child welfare services has just opened a case? How do we make sure that happens?

I'm sure you have seen the social ecological model before. We need to do something at each one of these. For me, this has been the easiest to understand, that if we are really going to address child maltreatment prevention we need to do something at each one of these steps. We can't just do it at the individual or family, we have to get all the way up there for policy and legislation.

So what do we need to do? I have presented some recommendations here. I want to spend a minute, because I think that's about what I have left, to tell you what I think the big recommendations are.

I think we need to work on having paid leave for a year after the birth of a baby for the family. It could be a mix of mother and father. They have it in other countries and they have lower child abuse rates. I think it is critical. And I think it is something we need to examine. Maybe we can't get to a year. Could we even do six months? Even six weeks, a paid leave so you don't have to use all your sick time and all your vacation time, and you don't have to get back to work at eight weeks?

The next big one, I think, is around childcare. I think we need to have universal, quality childcare available for every family. I think we need to figure out how we subsidize that, not just for families who are making \$10, 000 or \$20, 000, we need to look across the spectrum, and it needs to be quality. Because if we do that we are assuring where those kids are. I think we need to look at universal home visiting for one visit. I think we need to have a tiered approach. We have got the MIECHV Program, which you have heard about. It is doing targeted, one-time, first time mothers. Well, you know what? Great. But what about the mother that is on her fourth or fifth and she is 23 years old, and she has been in substance treatment five times. Who is working with her? Who is providing those services after she has the next baby? Look at Triple P. Good program. Evidence based. Has a tiered system. Some mothers maybe need one visit, some mothers need a visit every other week. We need to look at flexibility of funding. You have heard that over and over today. We need to look at how can we braid that funding? How can we merge it so that it can be used for where states need it and where families need it.

I'm going to leave you with these because I think at the end what we need to do is find that right balance between community and individual-based initiatives and services. Because what we need to do as a nation and a community is insure the health and well-being, and that is going to depend upon our children having a good start, a good future, good care, and good support.

And going back to my gardening, families need to be fertilized. I mean, they are telling me about the type of fertilizer they are going to use on their plants. Okay, I don't know much about plants, and most of my plants die, so they are going to come and they are going to do the intervention.

Thank you.

COMMISSIONER MARTIN: Thank you so very much. This panel has been delightful and informative. I do believe we have some questions by Commissioners. Commissioner Covington?

COMMISSIONER COVINGTON: Well I could ask all of you questions, but they would all get upset with me. I could take the whole time. I do have a question, because we have been spending quite a bit of time looking at the whole issue of substance abuse during pregnancy and the child welfare response, because my sense is that we send a lot of babies home with high-risk families without appropriate care, referrals and follow-up and we don't manage things well. Then those moms get into trouble, even later. So my question is past the pregnancy how do you support the families and what are you seeing in terms of outcomes over time? And tied into that too, is what do you do with moms who just aren't ready for treatment yet that are pregnant?

SALLY BORDEN: It is a voluntary program. When we started it we had no idea how many of these moms were going to sign this Release of Information, maybe none, maybe...we don't know. And we find that the majority of them do sign a release of information to allow the coordinated approach and the support services. So we have been really pleased with that. There is a lot of room for research on our little project. Each of the medical aspects or many of them have been researched by our University of Vermont Children's Health Improvement Project. But in terms of long-term outcomes and child welfare outcomes, that is one of our next recommendations, is that we need to assess that better. I can tell you anecdote that one of the shortfalls of the program is that it really, a few months down the road if somebody has been pretty stable, they sort of fall off our radar, because we are focused on the most high risk right now, and the current, the "Who is going to deliver next month, and what do we need to do to make sure that...?" "Oh. They haven't been showing up for prenatal care. Who is going to contact them? Did they show up for WIC? Oh, you have that address. Okay, I'm going to try and contact them and get them back in." So that is the focus of the team in the immediate sense. We would love to have better, longer-term follow-up. We do connect most of them with home visiting and/or parent education, and those are the kinds of services that child welfare is working to establish in the homes. So overall it is positive.

DR. HOLMES: So I didn't have an opportunity to talk about a major Medicaid initiative using a section of the Affordable Care Act, Health Home. What we did is essentially create a "health home" that supports categorical eligibility to care coordination, health promotion, and a whole host of the services that you would associate with a Patient Centered Medical Home around Vermonters who have opioid addiction. So what we have been able to do in that is take the good ideas from CHARM and BAMBI and the other kind of statewide replications, focusing around kids and moms who are pregnant and instead embed a nurse and a licensed mental health addictions counselor with every practice that is prescribing medication-assisted treatment. The nursing counselor, like the community health team, come free to the patients and the practice. They follow people in and out of treatment and for as long as we can keep finding them. So we are deploying that now statewide. What we are looking for evaluation is along the lines of a little bit of what I presented earlier. We will look at utilization and expenditures of key health care services. We will look at the common HETUS and other NCQF measures for initiation, engagement, treatment and follow-up. We also have, I am excited to report, just successfully received the go-ahead to get all of our Department of Corrections data. I work for the Medicaid agency, the Blueprint for Health, and what we are going to do is match corrections incarceration information to this cohort of people receiving medication-assisted treatment because we imagine that some of the best cost offsets for funding sustainability may not be solely in the health system but will accrue to other parts of the system. So it is sort of taking the really good work happening locally and then figuring out how do we make this global and put it in place as, if you will, our statewide approach and benefit.

SALLY BORDEN: So to finish answering your question, then I will challenge Beth to make sure that we include child welfare outcomes data with that study as well. Right? So we need to do that tracking with the child welfare outcomes and make sure that we are keeping kids safe.

COMMISSIONER MARTIN: Commissioner Petit?

COMMISSIONER PETIT: Two comments in response to something that Dr. Holmes mentioned, and then one question.

The two comments are be careful about what you wish for with regards to that tinge of regret of maybe not having authority with the healthcare system. I know that is not what you are arguing but I think that one of the reasons why people feel so benevolent and benign towards the health care system is that there is no legal threat, no one is taking anyone's kids, and no one is arresting anybody. So CPS is burdened in many ways with that, as we heard earlier.

The other thing I would mention is the Maternal and Child Health Block Grant. The Maternal and Child Health Block Grant was basically an entitlement until 1981. Now, 35 years later, or however much time has elapsed, it is one of the weakest funded programs. It has not remotely kept pace with inflation. And I say that as a cautionary note with regards to IV-E, which some people are talking about block granting. And what I would assert is that it is not mutually exclusive to be both an entitlement and to have flexibility. Both of those things are needed.

The question that I would ask and I think I'm probably in the right state to ask it. I think that your overall outline, as being the former Commissioner of Health in the state of Maine and running Medicaid and all the rest of the stuff, what you guys have outlined with your strategy to single-payer all of the different medical home that you have, I mean, I think it is just terrific and it is a great place to be going. But let's just think about something else. I have not heard one word today or for the most part in all of our travels, about the principal perpetrators of violence against women and children. And when I hear the words "We're strengthening families" I hear a euphemism of "families" equals "women". It is not very much with respect to men. So you look at who gets killed, who does the killing, who is in prison, who is committing suicide, who is committing murders suicides, and who is not paying the bills. These guys need to be pulled into this process and I am familiar at a very personal level right now with the situation of the birth of a child that included the father has got the mother and the father no longer drinking or smoking, and part of it is because of the father is so drop-dead crazy about the kid.

So I'm just wondering, as you have been a veteran in internal child health over a period of time and the rest of you as well, what do we do in terms of expanding this thinking to be maternal and paternal child health? I was at White House meeting recently and the vice-president was extolling the fact that all 50 states now had commissions on women and children. I said, "How many have commissions on men and children?" You know, it doesn't exist. And at some point, it is a real kind of a thing, because that is who is doing much of the damage. So where does that havoc get slowed down any, and is there any discussion that was in the field?

DR. HOLMES: I can speak to that. It is a great point. The evidence-based home visiting models work very hard on father engagement and parent engagement, and the curriculum, if you call it that, or the kind of strategies for the visit are laid out with the pregnant mom to say, "These are the types of things we are going to talk about in the next several visits. Is your partner available? We would sure like to have him at this visit." And what our nurses tell us is fascinating, which is often the man is nowhere, so that's just a reality. But if he is there, he hangs back and doesn't fully engage but clearly, in subsequent visits, shows evidence that he has been listening. So we are very interested in gauging family and parents, including fathers.

I think the other point that you made about the block grant is extraordinary. I will tell you one thing that we didn't get to address is that the somewhat new Director of Maternal and Child Health, Dr. Michael Lou...it seems like he's new and he's been here probably two years

now. He came in and said, "We really need to start showing the impact of these dollars to make it a sustainable funding," and maybe you all know that he went after infant mortality reduction. So the "COIN" which is not a good acronym, but it stands for something I hope you know, about collaboration, integration and...it has finally come to Vermont. We were the last cohort of states to come in because we have low rates of mortality and infants.

Anyway, we have done a lot of planning around infant mortality reduction and it relates very much to violence in relationships and our strategies are still being worked out, but we are thinking about this culture and the way it relates to incarceration and opiates. So thanks for that.

The other "win" that we had was around smoking cessation. We found that when pregnant women were smoking they had trouble quitting, and if they did quit they went back to smoking right after delivery because their partner smoked. So our tobacco program partnered with us to look at engaging fathers in the pregnancy around the health and that it is not just the smoking mom's responsibility. I try to go at little "wins" like that instead of the global issue in our society of how to engage fathers because I haven't been successful.

COMMISSIONER MARTIN: Commissioner Sanders.

CHAIRMAN SANDERS: Thank you. This has really been outstanding and a very impressive public health infrastructure and it is helpful to hear what it potentially looks like to inform us, as we are moving forward.

I think actually I was a little surprised Commissioner Petit didn't ask this, that even though there is a strong public health infrastructure you still have emergency rooms here and so I want to ask a question kind of taking the notion of the Child Protection investigation still being in an emergency room. A question about the links between the two systems, and it is really potentially for all four of you, but I think Ms. Tanzman and Dr. Holmes particularly.

We have heard a lot of testimony about the vulnerability of children under age five who are reported to the Child Protection Agency. We heard today the testimony of social workers, and the challenge, and doing safety assessments during an investigation to actually gather information during an investigation. We have read about the model of domestic violence where there is embedded domestic violence specialists with the Child Protection Agency. Have you thought about doing the same kind of thing with medical professionals to really help enhance both the investigations as well as ease the work for Child Protection workers?

DR. HOLMES: Absolutely so. A couple of things, one we do have a board-certified child abuse physician in the state of Vermont. She actually was here all day and just left, Karyn Patno, and she plays a really important role in our state in two arenas; one, she is the medical provider at our major medical center that does child abuse evaluations, including sexual abuse, and she is also a warm line for all practitioners in our state and the Department for Children and Families when they have questions about the medical issues around abuse and neglect, but she also plays a prevention role. She is funded in a very complex way to go out to our community hospitals and train community hospital employees but also families in abusive head trauma prevention.

But interestingly, the funding for that is all cobbled together. I am supposed to tell you the truth, right? (laughing) So it is all cobbled together and it has been a very difficult financial

situation. So in the context of all that has happened in Vermont in the last year the child health leadership of Vermont, so the American Academy of Pediatrics, Vermont Chapter wrote a letter to the governor and the secretary of the Agency of Human Services requesting the funding for a child abuse, child safe physician either in the Department for Children and Families or at the state level at the Academic Medical Center to be in the prevention arena and at the same time also the really valuable resource of the evaluations of kids who have already been hurt. So Cindy Walcott and I, as you heard earlier, the DCF and MCH work very well together in sort of system-level thinking, but on the ground we still kind of push the vision and then wait, and have to re-double back on it. So the most basic example is that we have MCH nurses in our districts whose job, when kids go into custody, is to get accurate medical information to the DCF, the very basic problem list such as allergies, medication, and immunizations.

So that relationship exists, but what we are trying to do is encourage people to see the connection between an MCH nurse and the DCF worker beyond that. It is very personality-driven, and a lot of it is about workload, right? To sort of open your mind both directions to the expanse of how much of a benefit it is to children requires time and effort. Some of our state office buildings are integrated that way, the DCF office is in the same location as the public health office and that works, but when there are different sites it is not as easy.

SALLY BORDEN: I was just going to comment that I think that the idea of embedding more of this in the E.R. environment, either with specialized staffing or raising the awareness and skill level of the staff who are there to work on these issues is a great idea. Thank you.

BETH TANZMAN: I guess I would also respond that I think the more we can expand the breadth of the team that goes in the better the investigation would be. I think it would be wonderful if we could look at sending in a team and that could be a nurse and a social worker. It could be if you knew there was a substance problem, a substance counselor as well so that it isn't one person going in. And maybe some people would say that is more threatening, but at some point involving more people. So maybe it is one person that goes in but having a broad team that can then look at the case. They have talked about broadening the team here. The better the perspective can be and understanding what is happening in that family, and the more input you could get. Involving the primary care physician. If they have, Medical Home that provider might have a wealth of knowledge and understanding and be able to provide.

COMMISSIONER MARTIN: Commissioner Rodriguez?

COMMISSIONER RODRIGUEZ: Yes, to comment on that last conversation. I think if there is any hope of meeting the holistic needs of the family, because it is never just an incident, it is always an incident that uncovered multiple issues. I think a model like this has to happen.

My question was so in my nine to five life, and I am a lawyer at the Youth Life Center, one of the things we have been looking at is, for young parents who are in the child welfare and the juvenile justice system, what sort of services and supports they are getting in their parenting? And part of the reason is that we have one large county in California that analyzed all their intakes and found that sort of the number one reason for substantiation had to do with having a personal history in child welfare yourself. That was above substance abuse and above mental illness. So we realized that is sort of a risk factor that folks aren't looking at. And one of the things I have been shocked with is, in going through and sort of talking to folks in the

system, how low the rates of utilization of things like home visiting, Early Head Start, WIC, subsidized child care, that actually this is a population of every at-risk parents who are almost completely disengaged from any of the public health programs that you all are mentioning and that are so promising. So I am actually curious, the broader population at large of children where there have been fatalities and near fatalities, how many of them are connected into these public health support programs. Do you have a sense?

DR. HOLMES: That is a great question. I can tell you that on WIC, and maybe folks know this, the federal government analyzes that for us and gives us a percentage of the eligible families, and we are in the 89%, 90% range for the percentage of eligible families that are in our program in pregnancy, but then it drops off. I think we were in the 70% range when kids are in the first year of life, and then after age 2 it is like 60%.

COMMISSIONER RODRIGUEZ: I may be asking the opposite question.

DR. HOLMES: To say it from your perspective there is 10% of people in Vermont who are eligible for WIC that do not access WIC. That is an at-risk group that I am fascinated with finding. I am very interested in finding them in the obstetrical practices because we have the best rate of first trimester care in pregnancy in the country. Again, in the high 80%, sometimes 90%, depending on the year. We also have an extraordinary uptake of home visiting, which people have not believed it and I wish I had brought it to show you graphically. But we get, of the women that are referred that are actually eligible for our home visiting program, 70% that stay in the program for a year. Which most home visiting retentions statistics are in the 20% to 30% range. But I still feel what you are explaining, there is a group of people we don't know.

COMMISSIONER RODRIGUEZ: No, it is actually a question. Of the fatalities and near fatalities do you have a sense of how many of those children and families were connected with any of these public health...I'm wondering is this a population that is engaged or is it a disengaged population?

DR. HOLMES: I do not know that.

SALLY FOGERTY: I think it would be hard to say because I'm not sure we are linking our data enough to know that. I mean, that would really require the multiple systems to really talk to one another data-wise, and be able to know that let's say "Billy" was in the Youth Justice System over here, they have a baby, but whether they were in WIC, I don't think we know because I don't think we always link our data enough to know that.(inaudible - interruption).

The child death review could be one of the real areas in which you could look at that to really collect the data to find out what is the history of the parent? So it may be one of the recommendations is to make sure that child death review does an extensive review, if possible, of the services and of both parents to the extent that they can, because you may not be able to put it all together. But I would guess that the other issue is we have a pretty mobile society today, and remember even if you know within a state you don't cross lines. And when you are living in the northeast, what I learned is you are in Vermont, you are in New Hampshire, you are in Massachusetts, you are in Maine...those lines are sort of fluid back and forth. So in some ways you are almost asking for sharing data across state lines. Now you are the attorney. Boy, that one is going to...we have difficulty just finding out in states information about births. Good question though.

COMMISSIONER MARTIN: Thank you. Commissioner Horn.

COMMISSIONER HORN: I'm going to dig a little deeper on this because it is an issue that I'm struggling with. Everybody is talking about big data these days, and predictive analytics, and we all know that whenever you go on Facebook they know exactly what it is that you have been shopping for, and your ads are next to it and all of that. I see the potential for really good things happening with data sharing and predictive analytics. Indiana, by the way, is doing a predictive analytics study. They are one of the worst in terms of infant mortality rates, and they have just started a project using big data and predictive analytics to try and figure out why and how to target interventions.

DR. HOLMES: I would agree with you.

COMMISSIONER HORN: But here is my question. This is what I am struggling with. There are two issues that come into play, it seems to me, when it comes to sharing information. Well, there are more than two, but two that I am struggling with. One, is confidentiality and the other is privacy. So confidentiality has to do with the obligation of a state or government agency to keep information confidential unless there is a good reason to share it. The other is privacy, which asks is there an expectation of privacy on the part of individual citizens? We are hearing this a lot with NSA and all that. What advice...because I get it. I get that we collect a lot of information in government, we have a lot of information available to us, and on one level it makes a great deal of intellectual sense to use that to reach out and provide services, but how do you balance that with particularly the expectation of privacy and the need to keep information confidential? What advice do you have to us, or at least maybe to me, and maybe everybody else in this panel has got it completely worked out in their minds but I don't. What advice would you have for us?

BETH TANZMAN: For me, I would say there is two sets of data. There is the data because the family has been reported as active in the system, and you need to share some personal data across programs in order to make sure that the services are in place that they need, and then I think there is the "big data" part, which I think can be done in a de-identified way. I think with the data capacity we have today we have the capacity to de-identify that data and to be able to then down link into the other data sets. And there are some states that are doing that in a very good way. They have figured out how to de-identify it so Billy is never known by "Billy". And to be very honest and to answer her question, I don't need to know if it was Billy or not. I don't need to know if it was George or if it was Mary. What you want is the information to know who is linked in and who wasn't? Did it make a difference that they were linked in? What is it we can do in dealing with that? I actually think we can do that we just need to figure out who holds, I guess, the identifier up here, and that can be so far removed you never can identify him. And I do believe we have the data security to do that. Then people are looking at the data always on a de-identified way.

SALLY FOGERTY: I don't have an answer. We had an opportunity recently at the Blueprint for Health. We were approached by an IBM team that ran a whole thing called CURRAN, which is designed to do predictive analytics for actionable health information across big, messy data sets, and we were really intrigued because a lot of the data sets are not nearly as clean as we would like to think they are, and you start trying to actually match up individuals or link them and people are dead, alive, active and...you know, it's a big mess. So we have begun to explore in Vermont the opportunity to enter into a relationship where we might actually try

to study and test some of these things and try working them. CURRAN was actually an Irish product that they were interested in trying to test a little bit here in Vermont. So my recommendation, if I were looking for good answer around that, is I would look to some of our partners in Europe about how they are using big data and predictive analytics for social welfare and social health issues and I think we could learn from that.

SALLY BORDEN: If I could just jump in with one quick thing, is that I don't have the answer either, but I think one barrier is that we assume that people aren't going to want to have their information shared so we set up barriers to that sharing and we don't make efforts to explain how the sharing of information is actually beneficial to the patient or the client, and what information will be shared and putting them in a driver's seat, in some sense. So that is especially true in a multi-disciplinary approach. So you go to the hospital and you assume that the ER doctor is going to share the information about your heart palpitations with your cardiologist, and that is going to happen. But we don't assume that things are going to be shared across agencies because, "Oh no. It is confidential and that is bad. We can't ever share that." And we don't then take the next step of saying, "I would like to share your information and this is how it will be beneficial." Let's do that. Let's figure out how to do it and create systems that can make that seamless, and certainly electronically, we ought to be able to do that pretty well and not create artificial barriers with assumptions that information needs to be confidential.

COMMISSIONER MARTIN: Thank you. Commissioner Rubin?

COMMISSIONER RUBIN: I am going to say something critical right now. And it is only because I think you guys are almost there. I am also a pediatrician so I think I earned the right to be self-critical. We talk a lot about Primary Care Medical Home and the fundamental belief that it is at the core of a population health model, and it is upstream to child welfare. But I would argue, even watching the slides go by, it is not operating that way. The information flow is one way. It is only when Primary Care decides it is ready to make a report and maybe they are lucky enough to get some information back from child welfare. But what you start to realize is that Primary Care Medical Home cannot be useful unless that pediatrician, or that family doctor, or that nurse practitioner, or whoever is operating in that home has all the information available to them to make their own risk assessment and try to tailor family-centered needs to that family. So this gets to what should a health information exchange look like for children, whether it is me or Primary Care Medical Home, and why isn't child welfare history permitted to flow into a Primary Medical Home, just like it does in Scandinavia where the confidential doctor relationship is set up, and it also gets to even outside child welfare's sphere. I have yet to hear of a Medicaid program that is calling the Primary Care Medical Home to inform that their infant that they cared for has been in three E.D.'s in the last six months with injuries. So we are not currently taking advantage, in terms of placement of programs, whether it is domestic violence programs or...you know. The programs that we are now starting to co-locate here in Vermont in the child welfare side, I am not seeing those enriched into those Primary Care Medical Homes except for grant funded or local experiments that we talked about.

So here is the money question then. What is it going to take on the confidentiality and on the information sharing side to enable the information exchange to strengthen a Primary Care Medical Home? Secondly, like we talked about for child welfare finance reform, what are some fixes in Medicaid finance reform that would strengthen the hand of Primary Care Medical Home to really be effective for children and families upstream?

DR. HOLMES: I can answer the first one, and you answer the second one. I would turn it back. I really appreciate your candor. I would turn it the other way. I don't think we need child welfare to figure out how to break down the barriers to share information with the Medical Home. I think the Medical Home has to do its own screening and assessment for the reasons that this gentleman said earlier, which is it is such a safe well worked out place for social good. People bring their kid to the doctor in Vermont, we know that for certain, and I didn't show that data but it is pretty extraordinary, especially for the most vulnerable kids the first two years of life. So I think what it would take is additional resources, not money but humans in the medical practice to do the family assessment that would give the doctor and the system the information they need to move forward, and then you can pay for it. (laughing)

BETH TANZMAN: So Primary Care is still a resource of all your base business, and relatively under-resourced. All the payment reform that we have put in place for our Patient Centered Medical Homes in Vermont totals to a tiny, paltry \$4 or \$5 per person per month, and that is including the community health team. What providers tell me is that they are still on this sort of 15 minute of needing to just push people through and through. So what I would say and what they are telling us is that we have to start to dial up the other kinds of payments that pay for population health and quality and sort of dial down this fee-for-service mill that they are on. With Primary Care also clearly we find that they do a lot of sort of soft things in terms of learning collaboratives and other ways of disseminating information and improving practices and they respond very well to that. I am very impressed by the ability of the ECHO Program to be able to rapidly deploy across a diffuse network very high-skilled, highly sophisticated interventions around complex conditions that Primary Care providers may not see as frequently as you might like. So I think it is both a resourcing Primary Care and then also a continuing to raise the bar around practice. So how do you do a really good developmental screen? We were looking at data just yesterday that showed we had close to 80% of kids getting appropriate developmental screens that (inaudible) age zero to 3, and my own boss, a pediatrician, said, "I don't believe it. I don't believe they are doing the Building Bright Futures developmental screens age zero to three. Do you have any idea how hard that is to do?." They figured out how to bill for it but he was not, as a pediatrician...he couldn't believe that we were having that kind of a rate. So we are not there yet, you are absolutely right to call us out on that.

COMMISSIONER MARTIN: Ladies, thank you so very much. I have to tell you this has been one of the most fun panels we have had today. So thank you for your humor but also thank you seriously for all the information that you have been able to impart to the Commissioners.

Ladies and gentlemen, that concludes are days of hearings today, and we look forward to seeing you tomorrow. Thank you very much for your patience.

DAY TWO—OCTOBER 24 2014

Note: Friday AM recording garbled through entire recording.

Note: Words in double slashes //Word// indicate interruption by another Commissioner.

NO INTRODUCTIONS

CHAIRMAN SANDERS: So I think we have everybody either here or on the phone with the exception of Commissioner Zimmerman. So we should go ahead and get started. So this will be the first time that we have the discussion of the Subcommittee work. It seems that there are a couple of things that we need to make sure we're doing. One is there's obviously going to be a lot of work now with the subcommittees. There's a lot of information gathered and we want to make sure that the full commission is hearing all of the information, or at least the key information and supporting, endorsing, however you want to handle that and that it's also coordinating because ultimately this all has to come together in a report. So as we gather information and talk about what we're doing, really look at how it's going to be pulled together. So that's really what today is...the plan is to do this on a regular basis so that as we move forward with the subcommittees that we're all hearing some of the key issues that are being faced and we are all able to weigh in.

So we're going to go subcommittee by subcommittee and hopefully we'll be able to cover everything this morning. Why don't we start with Commissioner Martin?

COMMISSIONER MARTIN: Would you mind starting with someone else?

COMMISSIONER HORN: Can I ask a question? I'm a little bit confused as to where we are in terms of what meetings are supposed to be public and what meetings are not supposed to be public. If I recall our initial briefing, more than two commissioners are discussing commission business do have to be open. So is there clarity? What can the workers do?

COMMISSIONER BEVAN: The subcommittee has to be open, no subcommittees can be closed.

CHAIRMAN SANDERS: Actually, what I'm going to suggest. I think there are some gray areas in there and I think we probably have to decide as a Commission where we want to push and where we just want to say this is just okay. So what I suggested is that...Amy and I kind of looked at the issues more closely and come back to the full Commission with kind of more of a sense of, where that gray area has been. Then where we want to follow that. I think that this is a gray area. This morning it's a gray area. It is the subcommittee reports so in some ways it's not actual Commission deliberation. This afternoon it's more deliberation 'cause we are actually going to have recommendations and talk about those recommendations. But, it is a gray area. We could decide that we want to have this kind of discussion open or we could push it and say, this is important have it closed.

COMMISSIONER HORN: My experience with gray areas of government I like to have government lawyers tell me whether I'm on the right side of the law.

CHAIRMAN SANDERS: And we have GSA [General Services Administration] telling you. We have GSA that is providing legal services to us. So it will give us an opportunity to do this. To act more extensively with our GSA attorneys about what the perimeters are. Come back here with some ideas about, at least our thinking that we want to put forward for this mission. Then we should make a decision for the Commission and where we want to land on some of those issues.

COMMISSIONER HORN: And we'll have that opinion in writing?

[phone ringing]

CHAIRMAN SANDERS: I'm sure we can do that.

COMMISSIONER HORN: I think it would be more language involved (inaudible-garbled recording)

CHAIRMAN SANDERS: We would share it with everybody but I wanted to make sure that a couple of us were actually looking at it more closely and come back to the full Commission.

COMMISSIONER HORN: Okay. Is there a requirement when you do closed sessions, is there a requirement to do public notice?

ELIZABETH OPPENHEIM: Closed, no.

CHAIRMAN SANDERS: You have to note that a session is occurring.

COMMISSIONER MARTIN: The subject matter, right?

ELIZABETH OPPENHEIM: Not if it's closed. If it's open, yes. You have to note. Every public meeting has to be noted.

COMMISSIONER MARTIN: I thought you had to notice that it was a closed session and that it falls within one of the exceptions of a closed session, but I don't know.

CHAIRMAN SANDERS: We'll come back to that.

ELIZABETH OPPENHEIM: We've been going back and forth, Chairman Sanders and I, with the GSA about that because there's two big sessions. That's where the gray areas are and how you interpret those. Whether it's a preparatory meeting. Clearly, this is not an administrative meeting because we are not talking about travel authorizations, all of that kind of stuff. But preparatory meetings how...I think you all received the definition on that from me earlier this week and that you just have to have a good reason...be able to stand on why you closed it. I've never been told and I don't see the language I'll go back to look at it that under FACA you have to note that it's a closed meeting. We should look for that. That's important. The other thing is that the Administrative Conference of the United States is back in business. They have some really good opinions about FACA. It is a federal agency and they provide a lot of excellent work and support for administrative agencies on the law. I just emailed them and said what do you have. Because I'm getting very limited information from GSA in terms of the background and how the things have been interpreted. So that is a great question and we should put that out there and get you all feedback as David said. I've been going back and forth with the GSA attorney on that. Great question.

CHAIRMAN SANDERS: You'll have something for the next meeting.

COMMISSIONER HORN: Fantastic. Thank you.

COMMISSIONER COVINGTON: If we have a closed meeting today and I want to deliberate on something. Is anything we do then able to be on the record? Or is this all not in any record?

ELIZABETH OPPENHEIM: This is all on the record. In fact, it's being recorded and there will be a transcript. So if anybody wants that it will be provided to the public. If it's requested under FOIA.

COMMISSIONER MARTIN: I thought that closed meetings...I'm sorry, it could be FOIA. I thought that's the point of a closed meeting that it's not available for the public and that's why it's not recorded but notes are taken and the notice would say, the purpose, say "For personnel Issues". After we come out of a closed session, we vote on whatever we need to vote on and then put a summary on the record. "We talked about personnel issues, resolved X, Y, Z." That's how I understood ...

CHAIRMAN SANDERS: So that's why I suggest let's work through this. Come back next week and make sure that the whole Commission has the broadest information about this and then we can decide what we want to do about it.

COMMISSIONER PETIT: Yeah, after the issue is still...it's paramount to have an open meeting if you're taking and recording the whole thing. That's not a closed session. A closed session in that case means you can't talk and no one else can interrupt the discussion of the Commission. (inaudible-garbled recording). I think the issue for me is it may or may not be reason why we want to be able to discuss something without going out to the rest of the world. There are occasions when that happens I don't know what that would be yet but I do know that it means that it may interfere with the protocol discussion or not but I think we need to get clarification. A closed session to me is (inaudible-garbled recording).

ELIZABETH OPPENHEIM: What I would suggest is that at our November meeting that have not been put on the books yet that's on the conference call. That we have part of that agenda include an overview of what's FOIA-able, as they say, and FACA. And also revisit some of the ethics on using (inaudible) from OGE about making sure that all of you, for example, are not lobbyist and those types of things. I think it would be great to have an overview, have some material sent to you prior to and then send questions and answers. .

COMMISSIONER COVINGTON: You can be a lobbyist. You can be a lobbyist and be here. The way you said that makes us nervous. (laughs). Bye Michael.

CHAIRMAN SANDERS: Why don't we talk about that one... let's not get in to all that

ELIZABETH OPPENHEIM: You can be... let's talk.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER PETIT: Are we being recorded or not.

CHAIRMAN SANDERS: Well it seems like we have the recording set up for today, we should figure it out.

ELIZABETH OPPENHEIM: So we can take notes of it but then it's FOIA-able. Again, it's my sense of this when Chairman Sanders and I talked about

CHAIRMAN SANDERS: I don't think today is going to be a big issue because it's primarily about the subcommittees but I think we will have clarity on this before the next meeting. There is something that we shouldn't talk about that might be recorded about subcommittees....

COMMISSIONER PETIT: Let me just give an example. Let's just say that one of us very critically spoke about Children's Bureau or something like this. And it's taken out of context and that actually, I've been informed, you have been informed more, you take that on without a position at all, whatever it is. All of a sudden, you have this stuff floating around that says so-and-so is criticizing so-and-so that can be distracting in terms of where the press goes, where the lawmakers can come in, the department goes "wait a minute I take it all back." It's just...it would be useful to know whether it is or isn't available to the public. So if it's going to be recorded David I think it needs to be recorded with....

CHAIRMAN SANDERS: Today? Are you talking about today?

COMMISSIONER PETIT: Yeah, if today is to be recorded the time being, if all goes to hell, clarification on. If none of the requirement says you absolutely must release it. Fine, but that will...but it will affect how the discussion flows

ELIZABETH OPPENHEIM: Can I clarify something about that? There's proactive stuff that you have to do by law that you have to provide, which is meeting minutes primarily and that we have done. We've made transcripts of meetings available as well. We have gone beyond the requirements of the law in terms of proactive provision of information to the public. We have to provide agendas. We have to provide Power Points that have been presented at the meetings but, for example, today's meeting we have it but we don't have to...we wouldn't proactively provide and list all of them. It's part of the record of the Commission.

COMMISSIONER HORN: But it's FOIA-able?

ELIZABETH OPPENHEIM: It's FOIA-able. We should talk about that because also all your emails are as well.

COMMISSIONER PETIT: So let's talk about it.

ELIZABETH OPPENHEIM: So we're going to do that? Send out a briefing piece to all of you prior to the next meeting so everyone understands where you stand in terms of federal law.

COMMISSIONER RUBIN: I just want to know, you know if Webster's adds new words to the dictionary. Has FOIA-able made to the (laughing) as a new word?

ELIZABETH OPPENHEIM: Well Joanne was asking, she never heard it called FOIA-able before. She only heard it called FOIA.

COMMISSIONER COVINGTON: Well, when you say our emails are FOIA-able, I thought any conversation I'm able to have on the Commission is not official Commission business.

CHAIRMAN SANDERS: Let's not get into this any further. I think we'll bring back something concrete, I think the taping of today we'll hold it or do whatever we can legally do to make sure the information is inaudible-garbled recording). We'll have a discussion specifically on this topic before our next meeting.

COMMISSIONER PETIT: So this meeting is going to be recorded and it's not yet determined whether the transcript is going to be made available to the public?

CHAIRMAN SANDERS: We will have the transcript unless we have to make it available to the public we will not.

COMMISSIONER PETIT: So I'm going to suggest that we treat this discussion as being on the record and that it's going to be...the default is it's going to be made available. I may not recommend that but it's not our fault but I think that has to be...

COMMISSIONER COVINGTON: That is a good premise for today.

COMMISSIONER PETIT: Whether it will comment anyone's comments or not remains to be seen. We'll see the passion of the moment. (laughing)

(inaudible - several Commissioners speaking at the same time).

CHAIRMAN SANDERS: Judge Martin you wanted to wait?

COMMISSIONER MARTIN: Yes, if you don't mind.

CHAIRMAN SANDERS: Jennifer, Michael and Bud Cramer. You want to start?

COMMISSIONER RODRIGUEZ: Sure. So our subcommittee is on children that are known to the child welfare system and we have met two and a half times. We have had...well primarily what we have been doing is trying to get a sense of what the scope of the commission is and what some of the important questions are. So you'll see in your packet there's a document that lays out a number of the questions that we've identified as being relevant to our subcommittee work and so they include everything from one of the initial questions that we started from is around looking at those counts that have been presented multiple times. About 30 to 50 percent of children that die who are known to the child welfare system and whether or not that number is accurate. We don't believe that number is accurate we believe it's probably a pretty severe undercount based on a narrow definition of children that are known to the system.

There is a number of ways that children might have come into contact with the child welfare system and then not be included under the system definition, for example, the call was made to a child abuse hotline and then screened out. It's not clear that that child ends up included in the official count. So that's sort of been one area we think it's really important to clarify because that changes...if the majority of children that die are children that, in fact, had some contact with the child welfare system at some point I think it changes the discussion somewhat about those interventions and abuse sources that are necessary. So that is one issue.

Then we also have been having a number of other discussions about the system's capacity to be able to serve children who are very high risk. Even when they are under whatever that definition under the child welfare system so everything from the way the calls are handled and decisions are made about screened-in are screened-out or referrals are made to outside agencies, to the way that investigations are handled and what best practices we know about

like predictive analytics or joint investigations that are collaborative with different agencies. In addition, we have talked about ongoing monitoring about child safety. About looking at children who are actually in the custody of the child welfare department and how their safety and well-being continues to be modeled. For example, there have been a number of cases over the last month of children who died while in foster care and when there is abuse or neglect by a foster parent do those cases get handled the same way that an abuse or neglect case is being handled from a child who is living at home. So an official investigation opens, entered into the hotline versus a licensing investigation being opened where there's be an administrative sort of area.

So I don't know if it makes sense to have walked through all of the issues here but this is basically the spewing of all of the potential issues for our subcommittee.

There's also what do we know about children under the child care and child welfare agency who commit suicide and are those children, children who die at home of abuse or neglect, children who are trafficked, how our caregivers who...just like what we heard yesterday from a foster parent who often knows the most about the situation of a family or risk factor that a child might be experiencing, how are they involved in sharing information and engaged and sort of the process for determining a safety plan.

Information sharing across jurisdictions. When a child is moved from one jurisdiction to another whether that's in-state or out-of-state how does that information get shared between different states and then I think that question that we keep coming back to which is, what interventions are actually effective for this population. What do we know about them, if anything and if there are interventions that are effective how do we work on scaling up and replicating those interventions and making sure that other states are aware. And then finally what do we know about prevention and support for young parents who are actually in the custody of the system where we have an opportunity to intervene and provide them with services. What can we do to prioritize them for services to make sure that they have access.

COMMISSIONER PETIT: Right now there are already several thousand children known to the parent CPS system that are going to be dead the next year or two or three. That is a fact. So no matter what else happens a bunch of kids are in the pipeline right now. That they are known to government agencies and as we see every day from materials that Tom was preparing day-in, day-out, day-in, day-out we're getting reports on children that are being killed who are known to the department. So I think that the issue for me, on this one, is CPS isn't going away. It's the legal vehicle that the government has created for in these cases and the issue is, what is that's necessary to strengthen the capacity of CPS on those cases that are on a very strong trajectory getting killed and what kind of thing should they may be doing less of. Not what should they be doing more of? What should they be doing less of and how do we more strongly integrate the civil aspects affecting children with the criminal law that is meant to protect children. Whether it's domestic violence of issues or whether it's prosecution of offenders, I think that where that nexus comes in, and we've been hearing some excellent examples of places where it comes together well, where it doesn't come together well. Yesterday I thought that it was a very good discussion on child advocacy centers with some presentation on that. One of the themes that we keep hearing, all of us, and individually in our subcommittees is the need for multidisciplinary approach to this thing. What we know is that it exists everywhere in the country it just doesn't exist every place that it needs to be in the country. There isn't a state I don't think that's having a CAC or multidisciplinary team. I think one of the issues for us is, how do we capture from locals, whether it's local police,

local state police, whether it's the child protective system, whether it's the emergency rooms in the hospitals but those first responders who come into contact with all this how can that happen in a way that there is no slippage, or at least we minimized the slippage of this thing.. We are not clear yet whether it's a function of law. Whether it's a function of resources. We heard yesterday, I was pretty impressed with the presentation by the social workers. You could have been in some other jurisdiction where the presentation wouldn't have been as have been strong if they weren't hand select 35, 45 percent turnover rate among front-line workers in a number of states which speaks to the impossible task ahead of them.

What we haven't gotten through yet is what kind of resource is needed. Are there deficiencies in resources? Are there deficiencies in training? What does all that look like and so Jennifer and I and Bud Cramer. Buddy are you on the phone?

COMMISSIONER CRAMER: Yes I am.

COMMISSIONER PETIT: And Bud along with Tom and Dan Scott. Dan Scott who was with the LAPD has been trying to just formulate what the questions are that he be positive both for ourselves and the Commission. I think one of the things that, I don't know if Jennifer if you or Tom have done it yet, we were going to put together a list of the information that we wanted to ask locally, I don't know, we said we would have it by today.. If you look at this there's need to communicate with all the CPS agencies, not just the five or ten states we're going to be in. The survey of them, survey police, survey PA's that need to take place. Survey emergency rooms and other critical responders. So in terms of what we can ask for and I guess there are some GAO or GSA limitations

ELIZABETH OPPENHEIM: OMB

COMMISSIONER PETIT: OMB limitations on what we can ask for. Who can ask for it? What can you ask? How can you record it, et cetera, so we're trying to figure out how we get passed that because we need that information if we are going to make informed decisions. Some David I think that the first task for us is what needs to be done to bolster the current system, whether it's modifications of law, modifications of this administrative practice or new resources. So we're looking at all that.

And last but definitely not least is we're going to tackle this I think in a subcommittee level but I think in the end it's a full committee discussion. It's what the proper role the federal government versus the state government in all this. How do those two payoff each other so that there is maximum protection of these kids. So we are very much looking at the public safety aspect of this right now, all to be complemented and supplemented by things like Public Health models and other specific things which we can take a look at. How they are specific things public health model.

COMMISSIONER HORN: Can I ask a question?

COMMISSIONER PETIT: Yes, Wade.

COMMISSIONER HORN: So as part of your committee you're going to take a look at I assume information sharing is a big piece. So do you also agree at looking at barriers information and what's allowed versus confidentiality and privacy and those kinds of things.

COMMISSIONER PETIT: Yes, Right. Yeah, absolutely. I think when you ask well what exactly does it mean to be a multidisciplinary approach to this thing? One of the principle things it means is sharing information in an open way that actually puts all on the same page. Another question is what is the legal capacity that I have and you have and you have and how do you tie all that together. At some point that's all about it. How do you surround the child with the full scope of the law allows for. That only happens if I know what the law allows for in your system, your system and what you know in my system.

COMMISSIONER RODRIGUEZ: I think it's really important because without sharing information we're actually never going to know what interventions are, actually.

COMMISSIONER CRAMER: Jennifer this is Bud. Can I jump in there and reinforce some of what you said and some of what Michael said and not for the subcommittee to dominate but as Jennifer said our subcommittee is looking at what is known, but it is important that we focus on what should have been known to the child protective services system and then taking the cases from there and seeing how that information is shared or if it's shared, what kind of specialization is going on and I think for me this subcommittee kind of is where the rubber meets the road and it's going to require for us to be careful about reporting back to the full committee because I think as Michael said this is going to trip into maybe next year's agenda for us to distinguish ourselves from work that was done in the 80's and 90's where they were talking about multidisciplinary themes and mandating multidisciplinary teams. I think it's our job to evaluate what's going on now, what resources are being committed to this. What child fatalities are slipping through the system and how we can make recommendations that are bold, effective, bottom-line recommendations.

COMMISSIONER RODRIGUEZ: I'm conscious of the fact...I think it's an issue for all of us in the subcommittee but to be careful, that there may be some urgency related to coming up with some recommendations based on the meeting that we had last week. So I don't know exactly...are we going to have a discussion at all about sort of how to prioritize and at some point I don't think it's a specific discussion to the subcommittee

CHAIRMAN SANDERS: Yeah, so on the agenda and we can broaden it or narrow it, is the interim report discussion and part of that idea is follow up from last week conversation. Just thinking about what is it that we want to prioritize as it relates to time.

COMMISSIONER RODRIGUEZ: Exactly.

CHAIRMAN SANDERS: I have three questions and all relate it to this. One is we talked about this it's children known to the Child Protection Agency because of NCANDS and so forth but we could equally think of those in terms of law enforcement because they have the legal responsibility in certain cases to investigate. So are we thinking about both or are we thinking more specifically about known to the child protective agency?

COMMISSIONER PETIT: Well let me just say first that the known child protective Agency is a concern and their concerns is the exact opposite of what NCANDS is representing it to be. That is they are excluding so many categories or contacts with the agency. Whether it's a call. Whether it's an investigation. Whether it's substantiated. Whether it originally for treatment Unless we can narrow the definition of family preservation services.

(inaudible-garbled recording)

COMMISSIONER PETIT: What?

Male: Reunified within five years.

COMMISSIONER PETIT: Unless it meets those two considerations. All the other cases are excluded for being known the CPS agency. So I think that that a piece that we need to take a look at I think that 30/50 figure is a figure they produced so I think we need to take a look at that. And I think that's why we need to survey the police. The police certainly gets (inaudible-garbled recording) calls about this but CPS. Say the teacher that was told not to call the police but to call CPS, who would call them. We would like to survey them. Find out what their capacities are. How they're setup. Whether they've ventured in to MOU, CPS, et cetera.

COMMISSIONER CRAMER: David, I do believe that we should not just make this focus on the child protective services system but the law enforcement is a direct focus as well.

CHAIRMAN SANDERS: It seems that the likely difference isn't on law enforcement it's just as great or not greater than the child protective agency. It's what they take in to investigate, where that decision is made, how effective they are in investigating, how effective they are in sharing with child protection. And giving that they have a legal responsibility, it does seem that's needed.

COMMISSIONER PETIT: One thing that is safe to say about all of this conversation is that many of us have been involved with multiple states and multiple jurisdictions within a state and the answer to that question is, yes, no and all of the above. There are jurisdictions where that's happening in a positive way. Just the way we describe it. There are other jurisdictions where it's the exact opposite. The police aren't going out there. The DA's don't make this a priority. et cetera, and when you have thousands of jurisdictions where all this takes place we base them on autonomy whether it's with the courts or with the sheriff or with the DA, we're talking generally, and then it becomes a question of what specifically those ratios would be. That's one of the reasons why we're talking about the sampling of the jurisdictions. I don't think we can survey 3,000 jurisdictions. But we can do 5 percent, 2 percent, 10 percent randomly selected that would give you some information.

CHAIRMAN SANDERS: So the second question is about, and, actually, Wade may have some thoughts about in this because I don't know this, the question yesterday that I asked the social worker about what would it take for frequency of contact. I don't know that that's something, are you thinking of that kind of issue as a part of the scope? I don't know if it's ever been anything out of the ACYF and ACF that really talks about, we're trying to keep kids alive. What does it take in terms of frequency of contact?.

COMMISSIONER RODRIGUEZ: I think that's definitely the type of issues that we're thinking about. Frequency of contact, type of contact and sort of what happens because, all of these issues, there are so many subtleties. Because having a worker that shows up, looks around the house so they can mark the check box probably isn't useful. But having somebody who actually goes in and talks to the child, looks at the child, talks to the family, that's useful. So I think those are all the things that we are looking at yeah.

COMMISSIONER MARTIN: So what are the things that, and I don't really know to what level you want to get on this question but, one of the things that I see in court often, it's not that

the worker doesn't go to the home. It's kind of like what you said, but for instance when the court orders unsupervised visits often times the worker will make the assumption that that means they don't need to go visit the home. And so it requires an additional order that I still want surprise visits. I still want unsupervised visits. So I'm saying that to say that when you get this survey and you look at your answers, I'm not clear of how helpful that's going to be. Because I don't know if that's going to tell you what to do and how to go. Because what I would be asking in that question is, yes, the judge ordered unsupervised visits at this point in the case but what does that mean in terms of worker contact. And remember it is not just the worker that has a statutory obligation to go to the home the guardian does too. And so just in asking that question I think you need to find the way to find out what the answer is on the ground as opposed to....

COMMISSIONER PETIT: I think what we're on agreement on is that we need to find answers. I don't think we'll find it here what the best way to collect that information is. When I used to do, when I used to head consulting for child welfare in the state one of the things that we asked in every state, among the workers was, what percent of your time is actually spent in front of the family as opposed to everything else. I would say the most common response was talks, 25 percent. The other 75 percent was largely documenting, it was collaborating, it wasn't being in front of the family. And in some jurisdictions they could direct services to go the family because there are services in the community. But in some places, especially in rural areas there weren't any other services. There was neither the social worker or there was nobody and they felt a lot of their time was consumed by the legal processing associated with taking people's kids away from them.

COMMISSIONER MARTIN: So my point is there are different ways that a worker contacts a family too. It's the very same thing. Cook County one of the things we try to do is compensate for that by having mediation and having workers and families come to the courthouse and actually, it doesn't really help on the safety of the placement but at least we find out what's going on with the kid. So I'm just asking you to think about that in a more expansive way.

CHAIRMAN SANDERS: One other thing, and it actually relates to some of the questions you had David. Frequency of contact of the physician may be more important than of the Child Protection worker. Just kind of thinking about it is, how do you put that together?

COMMISSIONER RUBIN: I was going to ask a similar question. So I called it descriptive workload and I would put it on this subcommittee. Last night we had dinner, Teri and I with a woman who helps run the Maternal and Child Health Division in the Health Department. Within the first 30 days of an investigation they assign a public health nurse who is on the Health Department goes out and assess medical needs. We heard from a domestic violence program that is now co-located. This distributed workload put more specialized eyes on the kid and their family and addressed the issue, how does the work of our Commission support the ability of local jurisdictions create those co-located distributed models. Because if we put more on a social workers they do not have that expertise, you are just putting more in the shoulders of one.

(inaudible - several Commissioners speaking at the same time)

COMMISSIONER RUBIN: The DV stuff is really starting to grow on me because we are barely touching the homicide/suicide which are all pretty much related cases and so the coworker of

DV cases with child welfare and how they take advantage on those services to assess risk and safety of immediate harm. Those are the kinds of things I was thinking of.

The second one was the predictive analytics. I know we had a session on predictive analytics actually having spoken to Susan, I'm not sure if she's on the phone. But having spoken to Susan, I don't think we have a really good appreciation of what that stand really is, because what it really is after I talked to her is it's not the demography, it's not what the kids are or what their backgrounds are, it's a pop-health analytic tool that said, were visits being completed, were notes missing and they actually look at the way cases transpire to use that data to say, "Oops need to hire someone to look over this case because this case is at risk of a bad outcome" based on the way it's being handled. I don't think we've got that full appreciation on how those models work but once I heard more about it I felt like, that does make a lot of sense because that's the kids slipping through the cracks because of the way we handle it. So I think that would fall in your subcommittee as to how do you want to bring a richer understanding of that potential of analytics is of preventing the kids slipping through the cracks.

COMMISSIONER RODRIGUEZ: Is that something that will be addressed hopefully in December?

CHAIRMAN SANDERS: I don't think so. I think we probably need to hear again with maybe some greater specificity as to how the model looks like from those who are viewing it. Because I think David is right, what I heard wasn't really impressive. What I heard in many other cities it's much more impressive and more along the lines (inaudible-garbled recording).

COMMISSIONER PETIT: Unless you want to respond to one of the points that David Rubin brought up, you go first, otherwise I have something to say.

COMMISSIONER CRAMER: This is not specific to David Rubin or David Sanders, whose last comment I didn't quite understand. But nevertheless this is a rock that's been picked up before. I think enviably we're going to need to look, in my opinion, through my work with the Children Advocacy Centers, part of the problem, or at least part of the issue here, and we've heard this in testimonies, particularly in Detroit and in Vermont now as well is the specialization. It's the way CPS, law enforcement, the entire system is structured. How they share information. When they share information. What about those cases where a child is killed where information was not, in fact, shared. We have to dissect all that and see what's working. If it needs specialization is that a resource issue? Is it an agency structure issue? You've got urban challenges, you've got rural challenges I think all of that is on the table.

COMMISSIONER COVINGTON: For me it's not even specialization in terms of information sharing. It's specialization in terms of services availability.

COMMISSIONER CRAMER: Yeah, I agree. That's what I mean. Yeah.

COMMISSIONER MARTIN: And not just the availability service but the quality of services.

COMMISSIONER COVINGTON: We heard somebody from Vermont, I don't know if it was actually at the hearing or during lunch or something was saying, it works really well in some of our, like in the urban area of Vermont but when we get.. the woman that Karen talked about how hard it is to get specialized care where she was (inaudible - several Commissioners speaking at the same time).

COMMISSIONER PETIT: Let me just say this. As far as I am concerned, that is the nature of what CPS is. Is take a look at the individual caseworkers. They're supposed to be managing, assembling, recruiting, paying and locating those services. If you look at the network of services that exist in the community I can tell you that United Way, Catholic Charities, Youth and Social Services about one percent of the spending that's going on in these areas is overwhelmingly coming out of the federal government and the state government in this area. They are being pulled together. The question is again I go back to the three thousand jurisdictions, how many of them are doing it right, in terms of textbook standard way, how many of them are not doing it at all, how many have the resources to do it, how many don't have the resources to do it. I mean, it really is a function of...the model that we're talking about I think it's vital that they embrace. The issue is whether they can execute money

COMMISSIONER RUBIN: That's right so what can we recommend to facilitate this.

COMMISSIONER PETIT: No, no that's exactly right. What I'm saying is there is a collective responsibility already. CPS is the poster child for it but any child protective worker that's doing their job is trying to manage all that.

COMMISSIONER MARTIN: Let me just push back a little bit. I certainly don't have the experience David and Wade has in social work and what a social worker is supposed to be. But I will tell you in Cook County and the judges that I talk with we are already at the point of trying to distribute that work. So it may be the social workers responsibility but just like I said when I see that the social workers are not getting out to the homes, I bring them to court. So what we're trying to do is mandate that they come to court so that we can put eyes on them. I have CASA, I have a medical specialist for CASA for the kids that have medical needs. I have a special CASA that's training...because we know that workers are not doing it and I think it's actually unfair to ask a social worker who doesn't know anything about medicine to really be able to tell me exactly what the doctor is saying this kid needs.

COMMISSIONER PETIT: I'm not sure what the pushback is. I agree with what you just said. I think that the social workers we do have as part of their part of acting in this thing, as part of being a case manager they do have a responsibility to make all those things. They're clearly not doing it in a lot of jurisdictions for whatever reason. Usually it's a resource question on handling case load. . When I asked a guy yesterday, what will be the right size case. He said one, do you remember that?

COMMISSIONER MARTIN: Yeah

COMMISSIONER PETIT: I think that reflects what happens when you try to manage lives of other people. I mean, we have trouble managing our own lives now we're managing other people. Social workers have 20, 30, 40, 50 cases up to 80 or 90 cases that are just a pretend situation.

COMMISSIONER MARTIN: So I think that's the issue. We're not supposed to be managing someone's life. We are really not. We're supposed to be, I think, supporting them to get to the point where they can provide the minimal care for their kids so they're not in court. I think that's what we do. We try to manage someone's life when that's not what we should be doing. I think we should be helping mom be mom. As opposed to making mom follow our hoops that

we hope then...and that's a small point but I think that goes to kind of this work that we're asking them to do.

COMMISSIONER RUBIN: I use the example of the distributive model of Utah. Utah developed a system where they inserted some public health nurses of a ratio 1 to 50 sitting alongside child welfare social workers. Basically they said to the social worker, "Don't worry about the health stuff. We'll organize the meetings. We'll organize the health stuff." And that was one less thing and it's been a very successful model of getting kids into primary care, maintaining some level of continuity with the primary medical care. It's a really impressive model. It's done some really... So you saw that. I saw that a little bit with the DV stuff yesterday. Rather than waiting for a social worker to kind of have the Aha. Moment with the DV stuff, they just said we're going to sit this person in the office and they're going to take care of that issue. They're going to go out with you on the visit...and so that's, what can we do to facilitate, how do they finance that in Utah. How do they finance the DV counselor sitting alongside here and are there recommendations we can make that will facilitate a local place in making those investments.

COMMISSIONER MARTIN: That sounds great. So what's on the other end? Is that reducing DV in the home? That's what I want to know, 'cause if we're going to make a push and say that this is what the best practice is, I want to be able to say, we're doing that because it's going to work.

COMMISSIONER RUBIN: Then you and in evaluation. Then you need to evaluate it. I'm not sure that we're going to find research studies that have proven that it works but pragmatically it seems like the right approach.

COMMISSIONER MARTIN: And that's kind of my issue with this whole thing to be honest with you. I don't know mean it as carelessly as I'm saying it. But I don't know if we're...should we be about making recommendations that we're hoping work because it sounds like it should work on paper. That's what we've been doing for a long time in child welfare. And what I'm hoping is, and I agree so far we haven't seen a program that someone says, "We started this five years ago when we had 20 deaths and it's worked because we've had zero deaths for the last two years." I agree with you that sounds perfect and trust me that's what I'm trying to do where I work every day. But the issue is I really hope that we can somehow and so what I was thinking about the other day is, is this really a two-part project. Is this a project where we go out and find what we think and deem to be best practice and then come back while we help them figure out evaluation and then come back and actually look at it. Because it doesn't make sense to make more recommendations then we honestly don't know if they work other than us sitting around and being the good guys and saying this looks like it should work.

COMMISSIONER HORN: Maybe my comment would be helpful, maybe not. You can judge for yourself. It seems to me that part of what you said is we should be clear on our recommendations about which of our records are truly evidenced based and which...we're not sure.

COMMISSIONER MARTIN: It doesn't even have to be as far as evidence based but it just has to show some progress. You know what I mean?

COMMISSIONER HORN: For example, I was stunned. By two little pieces of information from this Commission. . One was that if you put the parent in substance abuse treatment they are more likely to re-abuse . That stunned me.

COMMISSIONER MARTIN: But it depends on what substance abuse, right?

COMMISSIONER HORN: There's lots of explanations.

COMMISSIONER AYOUB: Wade, can you say that again?

COMMISSIONER HORN: We saw data that said if you took, and they randomly assigned as I recall, people who were in substance abuse randomly selected for treatment versus those with no treatment. The ones that got treatment were more likely to re-abuse their kids. And you can explain it this way. There may be lots of explanations for it but it's at least a stunning data point. It certainly didn't prove that substance abuse treatment alone (inaudible-garbled recording) it may not prove the opposite either but (inaudible-garbled recording). The other was the statement that guardians and at litmus are making recommendations about turning their kids to the home and they've never seen the child.

COMMISSIONER COVINGTON: Oh yes.

COMMISSIONER MARTIN: Come to my courtroom.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER PETIT: And what would we see if we go in to your courtroom? They do or don't?

COMMISSIONER MARTIN: They don't.

COMMISSIONER RODRIGUEZ: They don't.

COMMISSIONER COVINGTON: They don't.

COMMISSIONER MARTIN: And then you ask them directly and the way they try to get around the question is we employee social workers and we send them out to investigate. The problem is, I will tell you, I literally have kids that they're coming into port asking for to violate mother's orders of supervision where she can take the kid out unsupervised (inaudible). And they want to violate it because the kid came back with bruises. The kid's mother is out on the courtroom. The kid's not hurt at all. No one even took the time to look at the kid. The kid's sitting there in the courtroom.

COMMISSIONER RODRIGUEZ: Well I'll tell you a couple of years ago I trained lawyers in California...we have a system where children are assigned counsel who are in care and I trained lawyers who were representing babies and toddlers who were in foster care and have to do effective representation based on sort of a sort of developmental model. Those lawyers said they don't visit the babies at all because they're not verbal. So they don't go...this is actually one of the offices, the children's law offices that are to be the best in California. So they do really good representation of teaming, because they've gotten it through their head, I'm going to go to talk to the teen, engage them, ask them about their case. On babies I asked

them "what does your representation look like?" They said, we typically talk to the social worker and find out what's happening, we read the case file and we go and we represent. "You don't ever go to see the child in placement?" "Well know because the child can't talk." So there's nothing...and this is our group of kids who are at most high risk and their lawyers are not seeing them.

COMMISSIONER RUBIN: I want to push back on something you just said. There's a difference between recommending that a domestic violence program be a part of every child welfare system because we don't have the evidence based versus the distributed word, which is a population health model. I do believe we have pretty good data called Kaiser Permanente that those types of discriminative work-flow models and actually can improve quality and reduce cost. So we're making a pragmatic. What we're not saying is we're going to recommend a DV probe. We're going to look and see what does it take to co-locate services and specialized services because we have plenty data that I believe that says social workers are overburden and that things are falling through the cracks. So we can make recommendations that whether it's financing or creative uses of funding, whatever, that will allow a system to locally innovative, which more than ACA does and then evaluate it.

COMMISSIONER MARTIN: David I'd like to agree with you but that doesn't say that it reduces the fatalities. So that's what I'm saying, it has to be clear about what we know we do. And so we can say...and I'm not saying that that's a bad outcome, I'm not saying it's a bad outcome but I don't want to say that that reduces fatalities when we don't know that.

(inaudible - several Commissioners speaking at the same time)

COMMISSIONER RUBIN: Maybe that's our research side of our proposal.

COMMISSIONER HORN: We aren't like to resolve this today and probably within a preparatory meeting that kind of discussion. We're just putting issues on the table. And I think you have all made a great job.

(inaudible - several Commissioners speaking at the same time)

CHAIRMAN SANDERS: Wade you had started a point, did you finish that?

COMMISSIONER HORN: My only problem was that...I would encourage your subcommittee to do two things. One is to look at what the ideal situation might be, what it would look like but I'd also like you to think about incremental reforms that will... I was stunned that guardian ad litem would make a recommendation turnkey without ever seeing the kid. I was stunned by that. And if we just said, you know, you can't do that. You have to at least see the kid once before you make a recommendation. That would be a really important thing.

COMMISSIONER MARTIN: That's just following the law. That's basically to say just go with the law. Let me just say this and I'll stop. (inaudible-garbled recording) I do believe in this idea of distributive workforce. But I will tell you one of the ways we're trying to compensate for this over burden of a social worker, putting all this on the social worker is, that we're distributing it within the court and that we're doing it, so we're doing it with constant, we're doing it with mediation, we're doing it with court family conferences in the courtroom. So we're trying all these things to get at making certain we have the information we need. Even if it's not coming directly from the social worker.

All I'm saying is that when I do all of that, I'm still not convinced, quite honestly, that my kids are better off today than they were when I started 14 years ago. And so when we talk about the work and improving the work, if we're reducing costs, if we're streamlining costs, if we're streamlining services, that's great, but let's not say that that's reducing kids in foster care, reducing fatalities if we don't know.

CHAIRMAN SANDERS: Can you get us some information on that? That you talked about the distributed workload.

COMMISSIONER RUBIN: (inaudible-garbled recording) We can pull up some information. I think once you have data you can systematic. Utah has data from its qualitative case review that shows the improve system performance of child well-being

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER COVINGTON: Can I say a couple of things that I thought, and they don't, this committee was going to look at and if not they belong somewhere. One would be early identification of known how well we are in identifying kids who come in to emergency rooms, are seen by physicians at the center and others and the whole issue around reporting of kids that are potentially in danger. How well we do with that. I think that's maybe...they're not quite known to the kids.

COMMISSIONER RODRIGUEZ: I think that would be children not known.

CHAIRMAN SANDERS: Right, I think so. Before the call.

COMMISSIONER COVINGTON: When we first set up the committees -- I guess I'll back up 'cause there was something else I was going to say about that committee that I'm on. Is I thought that was sort of a prevention committee and to me it's not just...the committee of Susan and David's, and all of a sudden to me it suddenly turned into kids that are not known to the system, where I think that it should be about kids that are known to the system and not known to the system in terms of what early interventions and preventions strategies should be.

COMMISSIONER RUBIN: It's sort of taken on that part. I mean, it's in there but it's sort of moving upstream.

COMMISSIONER COVINGTON: So I didn't like the part about making it kids that are not known to the system personally, 'cause I think it should be about all kids generally. So I didn't see that piece falling into that, 'cause it's upstream. It's not really kids that are harmed and not identified. I saw it as being more your committee.

COMMISSIONER RODRIGUEZ: I think our committee has a lot. The danger of having a lot, I don't mind that we have a lot but we won't actually be able to tackle everything or make recommendations that are really concrete. I mean, we spent an hour last time just talking about what our committee was going to talk about.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER PETIT: (inaudible-garbled recording) Just to reinforce this, that goes back to your point Wade on this thing, in terms of instrumentalism that I think is already in place. There's already a system that's in place. We're not about to abolish the system that's in place. So the question is, can we get the concrete to government, et cetera, on the right trajectory. There's 12 of us on this Commission we have eight or 10 staff that I can tell you that the conversation that we are having is going on in every state in one fashion or another in every big city. We've tapped the newspaper, tap the legislative so in terms of the specificity, which we can get to unless there is something blazing, flashing, red light that says, do this, just pick that one. The rest of this stuff I think is shaping it, guiding it, and saying you should look at this, look at that. The federal government has a whole arm of its government that's meant to look at this and the states employ hundreds of thousands of people in one way or another to interject themselves into this kind of thing. So I do think, I love hearing all these specific ideas but we're not going to be able to look at that. We have a whole research network of social workers, social scientists, that haven't gotten to this yet or haven't figured it out yet.

COMMISSIONER COVINGTON: But we have a voice Michael where we can take some of those and put them out there.

COMMISSIONER PETIT: I think we're going to push our voices as loud as possible. I think it's going to be careful that we don't get...I hate using that expression "into the weeds" but that's, I don't want to get too far down into that because we're going to end up ignoring a lot of other

COMMISSIONER RUBIN: I actually agree with you. That's why I made my point. Rather than recommending the program, 'cause I believe that's local, state and state innovation. Their job is to identify the evidence-based programs that they believe in. Our job is to facilitate the mechanisms by which they can innovate. Then test and evaluate whether they can have dramatic impacts on child abuse and neglect or whatever. Because I think you're right. We can be inundated whether it's Triple P, or evidence based, home visiting or...that's not the charge here. The charge here is to facilitate the ability, 'cause I believe the evidence is strong when you look at child fatalities. Kids are slipping through the cracks. Most of these cases share this issue that people don't communicate, people are in silos, and I do believe there's emerging evidence that when people create this distributive model that they do good things for kids. So the question is not, do it that way, don't do it Utah's way, but how do we as a Commission facilitate those questions...

COMMISSIONER COVINGTON: Okay. Can I go back? Kids are slipping through the cracks. Can I go back to my question of where we're going to put the issue of kids missing out every year and being unidentified?

CHAIRMAN SANDERS: I think (inaudible-garbled recording)

COMMISSIONER RUBIN: That's going to be in the non-child welfare. That's going to be part of our group.

COMMISSIONER PETIT: Just relate that. Just do the state thing. We keep forgetting the fact that this is 50 state jurisdictions make up their minds on this. If you take any indicators of outcomes in child welfare, whether it's removal rates, whether its fatality rates, whatever it is the difference between the highest state and the lower state is multiples of a hundred. It's not like 10 percent. It's 100 percent, 200 percent, 300 percent. So in some cases we have

great ideas, not ideas, we see good practice and they have much lower death rates and then you have states in which the government website disagree with you. They just don't want to make the investment for whatever reason. They are opposed to it or whatever it happens to be. There is a measure to this thing that goes beyond do we actually know. In some cases, we do actually know.

COMMISSIONER RUBIN: We do that integration work. That's where I definitely agree with you when I say we don't know...I challenge anyone to find evidence that we know exactly what prevents child abuse and fatalities.

COMMISSIONER MARTIN: I think we have seen something --

COMMISSIONER RUBIN: We know good practice that's pragmatic.

COMMISSIONER MARTIN: Where was that when we were talking about co-sleeping and they had this like piece of equipment, the box and they had a papoose and they put it in the bed?

COMMISSIONER PETIT: This is about proving nothing. Let me ask you a question. Do you think that today if child protective services didn't exist that there would be more kids killed?

COMMISSIONER RUBIN: Yes.

COMMISSIONER PETIT: Okay. so they're doing something in some cases. It's preventing death of children. So whether we can document exactly what it is but I think some of it is related to size of caseloads, whether the workers have been trained or not, what relationships is with others. I mean, there are some things. We may not have precise scientific confirmation that is the case, but that simple question about, you would have more kids killed. Of course, there would be more kids killed. There would be thousands of more kids killed.

COMMISSIONER COVINGTON: My concern is this, we think about making recommendations is that we not need some sort of generalized that it becomes jargon. It likes anybody can blow this thing up to anything they want to be. I think the more specific we are and the more focused and directive we are the more likely we're going to have the opportunity --

COMMISSIONER RODRIGUEZ: I think it's a balance too. If the balance is making big global recommendations chances that somebody will actually pick them up and do the work associated with our 50/50. I don't know what the chances are. Whereas if we go through small specific policy challenges that we can recommend that my not reform the system but will improve something slightly, then I think we shouldn't miss the chance to do that.

CHAIRMAN SANDERS: Why don't we go the second ...

COMMISSIONER PETIT: Can I ask a general question to the group to just think about this because it's in terms of the survey. You post the question; do you think the workers that are trained do better than the workers that are not trained? The workers that have a smaller case load than with all this? I think there's a question here, maybe we should do this, extending a bar chart which we've been involved with before. That shows what each state is on a continuum on this thing. Because they are not all the same on this thing. And in terms of being specific, part of this is prompting or prodding the states that aren't doing it to consider. So I think showing that there is vast difference among the states. We did a project in

Mississippi one time, they were spending \$24 million in the child welfare system that's the same size of population in Oregon, Oregon was spending \$240 million. The \$24 million being spent in Mississippi, \$4 million was state funds, \$20 million was federal. They were spending ten times more in Oregon in a state that had half as many problems as Mississippi. So I think this notion of disclaimers, which will definitely stir, because people will say, "hey wait a minute", and it gets people and the counties pissed off about this thing, no question about it. They'll think we're picking on their state. I do think that's a track that we should follow. I am curious to know if people feel all right about that? See where the data takes us.

CHAIRMAN SANDERS: I think it would reasonably come out of your subcommittee too. That's where the prosecutor (inaudible).

COMMISSIONER PETIT: Yes, all of those.

COMMISSIONER HORN: I think I can objectively state that the fact that all of this is being recorded is not inhibiting

(laughing)

COMMISSIONER COVINGTON: To your point though I think we have to be really careful when we compare states to make sure we're comparing them the same.

(Positive responses)

COMMISSIONER PETIT: I agree. There's a big disclaimer on that and when we say this is the best that we've got. So the best shouldn't be enough to write about, even if it's sufficient.

COMMISSIONER RUBIN: On the Public Health subcommittee, Teri's joining us now so it's going to be Teri, myself and Susan Dreyfus. Not here today, obviously. But we talked actually, had a call with Hope and Sara who are helping us on the staff to organize this group. And our priorities are to identify those systems that are involved outside of child welfare particularly more upstream, which system and programs often touch these children and families particularly in early childhood when we know most of the fatalities are occurring and then to try and develop federal recommendations. I wouldn't necessarily say federal but federal and or state recommendations to prevent child fatalities due to abuse and neglect for kids unknown to the child welfare system before they die.

COMMISSIONER BEVAN: Do we have that in front of us?

COMMISSIONER RUBIN: Do you have copies Sarah?... You can pass it around, yeah. So the activities that we determined were number one, in terms of need for new data. That we thought that it would be valuable to understand how many of these kids are actually known to Medicaid. I saw some data yesterday from 90+ percent of the kids in the state of a healthcare account. So I thought it was a really valuable part of the presentation by Breena Holms.. But we wanted to see if we could do some analysis and do a federal or a couple of states to actually cross the kids. I'd like to know who...of the kids who are dying, how many kids are known, to Medicaid, to WIC, how many of these kids were enrolled in the field of home visiting programs. So I think we need to be able to kind of look at the intersection with other programs. That's the new data.

I think we want to develop an inventory federal programs that are actually right now being funded to prevent child maltreatment or child maltreatment fatalities and a little bit about their evidence. We wanted to identify key stakeholders. I think what was unique, and one of the reasons we asked for this subcommittee, is that when you go into Medicaid or you go into WIC it's not so easy as just saying, even preparing the guys yesterday like Beth who I thought gave a terrific presentation of Vermont's waiver and what they're trying to develop. We need to spend time with these folks because they are no different than the child welfare folks. They don't spend a lot of time thinking at the same level detail that the child protective services system does. In many ways the strategy is to identify key people. Like, for example, when in Washington (inaudible-background noise) who is doing injury prevention in HRSA we can help work with her and have her work with her staff to develop some potential recommendation and by the time Beth comes to my meeting, she's already had a chance to do some internal work in HRSA and then can testify to the whole Commissions and it will be more valuable energy. The idea is getting to these systems. Identify the right players. Work with them as a subcommittee, let them develop recommendations and then keep you guys apprised to what we're doing by the time they come and testify you guys can be much healthier exchange.

We can lead to a discussion on the back end in terms of informing some of the key policy recommendations of the group.

COMMISSIONER PETIT: How does that relate to reducing child fatalities?

COMMISSIONER RUBIN: How does that relate to reducing?...because the same way I did with (inaudible) cases. I believe, for example, like, right now, show me a Medicaid program in this country that is looking at their Medicaid claims and identifying battered children in their first year of life and ask if someone has actually looked at those kids and have been seen. Some of the appraised the risk of that job. I believe that will reduce child fatalities. So to me this is about tightening the threads on that quilt that I talked about that these other systems that see kids, how do they appraise risks before the risk of the child is known and it's going to be germane to a conversation and Pat's going to have in just a little bit, which is how do we do it without over reaching because the last thing we want to do is have an unattended consequence of snowball in harm in terms of disproportionality. But you want to do it in a sensitive way that sort of makes people know Medicaid has skin in the game. They see all these kids in the first year of life. They see them before child protective services. How do we increase the sensitivity of that system to be able to function to provide safety to the kid. Some of that is through intersections with the child welfare system but some of that is about having information available in the emergency department when a child comes in to know how many, you know, or for someone at the Medicaid office to say, this kid had five injuries including three skeletal fractures in the last six months. Let's call Primary Care Medical Home to make sure that they've done a risk assessment, they can't get the kid in.

COMMISSIONER PETIT: What you've described is what they saw, why don't they call CPS? Make a mandated report.

COMMISSIONER RUBIN: Well you just can't look at medical claims and just on the basis of medical claims because the kid can have a genetic disorder, but what you can say is call a pediatrician and say, "Have you seen this kid? Can you get this kid in your office?" They get the kid in your office and the pediatrician assesses based on the injury history and the kid's

medical history whether it steps up the DCF and if they can't contact them then of course immediately report CPS.

COMMISSIONER MARTIN: The way I would answer that question is that we're putting more eyes on the kids and the following up on the kids that have some suspect of what may be child abuse, medically.

COMMISSIONER PETIT: CPS would know a lot of these kids and families before the healthcare systems. If there has been an already existing file.

COMMISSIONER RUBIN: Yeah, that's true. Let me give you another example WIC. So we have a child death, I don't remember what it was but the parents were going...WIC is supposed to do an eyeball check of the kids. The mothers are coming in they're getting formula. In this case I believe they were... they were using the coupons and they were selling them in the distribution for drugs. But they never actually unbuttoned the kid's thing to look at a kid who was completely skeletal. So it's trying, to me it's looking for the pragmatic solutions that there are things that these guys are doing every day and it's another set of eyes. How do we straighten that to make sure the kids are involved.

COMMISSIONER PETIT: Which staff would do the mandated reports. If they suspect? Not believe if they suspect?

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER RUBIN: If they would do it. If they suspect. So I think what you're asking WIC is, are the opportunities to working with the current system and where do you think there are valuable opportunities to just to ensure that...I believe, I started to believe at the end of the day yesterday that Vermont's numbers were real is not just that they're a small state. Statistically based on their population their fatality rate was lower. That's why we chose to come up here. Part of it is it's easier for them to get their hands around the population because it's a smaller state. But they have so many eyes on these kids. And so it would be very hard for a kid who is at a severe risk to not have been noticed by someone. I think, look, I can't prove that through research. But I felt, it just felt to me what that integrated approach has prevented a case.

(inaudible - several Commissioners speaking at the same time)

COMMISSIONER MARTIN: You have a better recommendation. From the death review committees we understand what we see a lot of is that kids fall through the cracks and they're just not eyes on the kid. So if we take that report and that result and put more eyes on the kid then I think it busts your argument. See what I'm saying? All I'm saying is let's make sure --

COMMISSIONER RUBIN: Let's just put more eyes on the kid.

COMMISSIONER PETIT: (inaudible - several Commissioners speaking at the same time). But the five deaths that they had in 2013 would not be less than the national average.

COMMISSIONER RUBIN: No, no.

COMMISSIONER PETIT: They have five. So zero counts but they have five and they only have a population of 500,000 and the death rate is of two kids per 100,000 children

COMMISSIONER COVINGTON: They had several years of none.

COMMISSIONER PETIT: They had a couple of years of none. Before that they had five. So you heard me yesterday say, "what a terrific set of initiatives to take with regards in managing the health care system." Whether it relates to reducing child fatalities remains to be seen and they have a very small number. So there will be a question of outliers..

COMMISSIONER RUBIN: That's what I say is what the common thing is this, put eyes on the kids. I'm just getting eyes on the kid.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER PETIT: I'm all for that.

COMMISSIONER COVINGTON: We've also looked at other places where they had more eyes on the kid and their numbers have gone down. We looked at El Paso. The counting in Colorado. We saw --

COMMISSIONER RUBIN: The integrated approach that they took. So the integrated approach between the military and civilian in El Paso, County they had a dramatic reduction in child deaths.

COMMISSIONER PETIT: Pick up the report that Tom forwarded to this morning on Florida in which there was a kid that was killed, several kids that were killed and everybody knew them for years. Many, many eyes were on them.

COMMISSIONER MARTIN: You're going to find them, Michael.

COMMISSIONER RUBIN: You are always going to find those.

COMMISSIONER PETIT: It's a common situation in which there were many eyes on the kid. The question is, what is the correct intervention. If the judge says, the correct intervention is to get her mother to do her job without supervising her. And I say no. The first part is to protect the child. Those are two different ways of approaching this thing, right. So I think we need to see what it is that goes wrong when everybody knows the kid.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER COVINGTON: I'm getting the sense of what you're trying to say is you don't really want us to focus on early intervention, primary intervention.

COMMISSIONER PETIT: No, not at all. I think that is an important --

COMMISSIONER COVINGTON: I thought you were saying you didn't want to do either.

COMMISSIONER PETIT: No, primary prevention, overall, that's right. It's not what our charge is. Some of those things, I mean, how far along are they?

COMMISSIONER COVINGTON: I don't think it is.

COMMISSIONER PETIT: Are they a year up returning benefits? Two years up? Five years up? And then the question is priority staff time.

COMMISSIONER RUBIN: Well there's two things. There are definite cases where we didn't have enough eyes on the kids and we did not look at the ability of whether it's health or WIC and now certainly the early childhood home visitation we have to...we are investing a lot of money in early childhood home visitation. We have to understand why they are or not struggling to meet their...what they'd like to be doing, which is child abuse prevention and certainly fatality prevention. So we're making big investments there so we have to understand how do we promote those programs for success. The case that you're talking about is the case where everyone thinks the kid is going to die like Mary Taylor case. Everyone knows about the kid. I believe that's for your subcommittee because the question should there be an elevated response for the kid that everyone is walking around talking about the risk for that child.

COMMISSIONER HORN: I think what you're saying and I agree with you is we would just encourage your subcommittee, I would, encourage this. (inaudible-garbled recording). That whatever recommendations to make sure there is a linkage. A clear linkage to preventing child abuse and neglect fatalities. So, for example, it was really fascinating to see about the Medicaid waiver. But the outcomes were, we save money in Medicaid. That had nothing to do with preventing child abuse and neglect.

COMMISSIONER COVINGTON: But it did because they were able to transfer that money the \$18 billion that they saved into prevention services.

COMMISSIONER PETIT: \$18 million.

COMMISSIONER COVINGTON: \$18 billion.

COMMISSIONER HORN: Look no one is stronger proponent of block granting Medicaid given its state's given flexibility) but I don't think that that should be an essential recommendation of this Commission to do that. Just make sure there's always --

COMMISSIONER RUBIN: Here's the problem that you face is that, for example, looking at kids with multiple injuries through their Medicaid claims and having a Public Health department take on surveillance of injury to kids. There's not a single program that's done that. We have no evidence but it's pragmatic...like it's such an obvious...in a lot of our interventions we don't have evidence. We have to make very pragmatic calls based on what the fatality data is telling us and that's the best --

COMMISSIONER HORN: There's a logical link. All I'm saying is I encourage you to always keep in mind that logical link. Why are we recommending this? Not because it's a good thing and you know everyone likes a flowering garden but because it actually has a logical link to the mission of this Commission

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER COVINGTON: How many people have we listened to that have presented to us that said, we could run around and check on children all day long, but until we move it upstream and start making families healthier and having the kids safer we're never going to get to the crucial point.

COMMISSIONER PETIT: When I saw Gloria Steinman in a tribute to the Michael Jerome case going upstream...I remember the first time I used that line in 1964 and all the people that I heard on the Michael Jerome case (inaudible-background noise) you only get these families. To me that's like when you get the common cold. It's something that we should strive for but there is the question of children dying.

CHAIRMAN SANDERS: We do have it seems more evidence today that the general surveillance system that leads to reports is identifying kids who are vulnerable. It does seem that if the only response from other professionals, nurses, childcare providers, physicians is to report then we're missing an opportunity. So it seems that it's clear there is something in terms of the intervention that can be offered before a report is made that seems that we have some evidence that it would at least be touching the right group of kids.

COMMISSIONER HORN: So let me put a fine line. There is the all claims data base for Medicare as states have moved from a deeper service to more managed care what a lot of states are talking about is looking at that data, help manage cases. That's a great thing. But I think what you have said was, let's use analytics to try to determine or identify those kids that based upon what we see in the claims would put them at high risk...

COMMISSIONER RUBIN: It's a managed care response.

COMMISSIONER HORN: So it wouldn't be a recommendation that said, "Gee we could match care better in America," is we should do this piece because this piece is linked to the mission.

COMMISSIONER RUBIN: We're sort of piggybacking on what's already going on in these programs and sort of elevating that. Whether it's quality measure, failure to thrive or a more active utilization of management around kids.
(inaudible - several Commissioners speaking at the same time)

COMMISSIONER HORN: On number two, as your activities. This may already be done.

COMMISSIONER RUBIN: Yeah, that's what we're going to do. We're not going to reinvent the wheel.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER HORN: ...on child abuse and neglect and they've done this. They've cataloged all that so we don't have to.

COMMISSIONER RUBIN: Absolutely, we're not going to reinvent the wheel. What Sara and Hope are going to do is they're going to figure out who has it and pull up all of the resources and show them.

COMMISSIONER PETIT: David, just one of the things I am reacting , I think I'm hearing certain things about what these states should be doing that I know, in fact, maybe they are doing,

have been doing for a long time and just not doing enough of it. For example, you mentioned childcare. Every child welfare system that I know is buying childcare some place, for somebody because they think there's a kid at risk and they think putting the kid in childcare would be beneficial. Numerous states employ nurses to go out and do a less threatening kind of surveillance or oversight to work with parents that isn't meant to be investigative. It's meant, and Public Health nurses have been declining in those states around the country. So there isn't a child welfare agency that I know of that doesn't have a large budget, not necessarily appropriate for the magnitude of the problem, but that doesn't have a significant sum of money that's available to buy services. Whether it's substance abuse, whether it's after school programs, whatever it is, I mean, they are all doing it. The question is, is it adequate in proportion to the size of the problem. And that's a different question. I am not promoting it at this point the initial spending, I'm saying that's something that does exist it just may not be at scale.

COMMISSIONER RODRIGUEZ: And I continue to have the concern that some of these programs actually don't outreach to and serve some of the most at risk homes that are not engaged. And I can just tell you that my experience in California at least with some programs that sounds really good and sounds this would be really helpful to at risk families, I think they're not taking them based on trying to get them in because they are trying to get better outcomes for their programs. I think there's some creaming that's happening because they have some grant funding, trying to figure out what it is but some of the families that I have personally referred over they just won't go and see. They're seeing easier families like the home visiting program. So I think it's really important that in looking at these programs, it's great to have more eyes, but making sure that the eyes are on the right kid and --

COMMISSIONER RUBIN: That gets to the disproportionality in it. We were talking a little bit about that last night.

COMMISSIONER HORN: That's interesting. Is there still risk of childcare development fund?

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER HORN: You might want to take a look at that because to your point...Risk for Child Care was meant to be for these high risk families in place where they (inaudible-garbled recording) by folding into the childcare development program that's what happened. I'm not sure how long the states are prioritizing or reserving a lot of its funds for risk childcare (inaudible-garbled recording).

COMMISSIONER RUBIN: Here's an example like, childcare, you can look at a lot of the cases. It's often a paramour. Who is killing the kids? A lot of them involve like of appropriate childcare but how deep do you want to go with the childcare.

(inaudible - several Commissioners speaking at the same time).
(laughing)

COMMISSIONER RUBIN: Well the physical abuse case, the shaking babies are principally now unrelated male caregivers. You have to look at that data. They're looking at both, so the co-sleeping deaths, who do think, it's usually been attributed to mom, sleeping in bed with the kid. So those numbers were a little bit elevated based on the fact that everything was mixed in but physical abuse cases are men, more than moms

COMMISSIONER PETIT: Much more than moms.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER RUBIN: I understand the caution of being...because I sort of stop with the prevention programs because I don't think any of our prevention programs have real data on fatalities. Some of them have data on child abuse or parent practice but again we're not going to find any really because the numbers are far too small to ever be able to measure that. So that's going to be the trick here of getting too far out and too confused.

COMMISSIONER HORN: I know I'm going to be a broken record on this and I apologize but again looking at childcare. There's two roads you can take. We are the rich Smiths on earth and we cannot run the risk of not giving free child care to everybody in America. Or you can say all we have is this thing called Childcare Development Fund, where respite care was offered to states need to prioritize and force the Childcare Development Fund or respite childcare for high risk families. Those are two very different recommendations. One is let's solve this overall problem. The other is let's solve all the world's problems the other one is more specific.

COMMISSIONER RUBIN: Well that's what I say too. We saw some home visiting program (inaudible-garbled recording) maybe home visiting programs should have prioritization for childcare if they create supervision issues at home and it's an unintended consequences, those are the kinds of pragmatic solutions that we may be able to make .

CHAIRMAN SANDERS: You two want to move forward to military funding?

COMMISSIONER RUBIN: I would say the military stuff and Teri...I actually think this is the type...we have a really perfect storm of an opportunity. I don't think we have anything written but we have a perfect storm of opportunity with DOD and family advocacy. There are good relationships. Teri has a great relationship at DoD Family Advocacy . I actually am working directly with Army Family Advocacy and with and with folks of a mandated research program There is data and it has been coming out like I said from this grant. There are two pieces of data that are going to be coming out in the next year. One that demonstrates the highest risk for serious physical injury, abuse, head trauma those type of abuse to the military children is in the immediate six months of returning from deployment. It makes sense that perpetrator is usually the sponsor, in that case the active duty Soldier. And we heard from Julie Nagen in El Paso, Family Advocacy in El Paso, that they have a great program around reintegration for soldiers. They actually reduced with a lot of their programs, but she was worried about standardization and Commander turnover.

So between that data and other data that actually is going to be more provocative there is this mechanism when a military child gets reported for child protective services family advocacy is supposed to know about all the kids who are, the children of service members. A lot of times reports are generated to the civilian system. The civilian system is supposed to actually communicate back to them on base so that they can provide services and resources to the family. We've always taken that as sort of, that's what happens. That's protocol. We know that military child abuse breaks in general are quote "lower than the civilian population". We did a study that looked at actual medical claims for child abuse and serious physical injury and non-fatal injuries we talked about yesterday in the first couple of years of

life. Only 20 percent of those kids, with a diagnosis of child abuse or a severe non-fatal injury were actually ever known to FAP. It was like pre-captive. Like in terms of the concern we don't know the overlap child fatalities in terms of kids who are known to FAP, not known to FAP, whether the civilian authorities knew about these kids and didn't report it back. On both those issues when we met at Union Station last week. Yeah, this is a tremendous opportunity for the Family Advocacy Program and the DoD to actually generate the recommendations to strengthen the mandating reporting to FAP the response of FAP on behalf of families across bases, particularly around deployment. So we sort of view this subcommittee as working directly at the highest level of the pentagon to elect and generate to use the committee as a vehicle to really protect kids better in the military.

So I think it's a direct, it's very pragmatic.

COMMISSIONER COVINGTON: They were at first pretty afraid when we wanted to meet with them, thinking we would come in and be highly critical of what they are doing but really instead they are so frustrated at their inability to touch their kids because of all these weird things going on in the civilian world such as... "We're not going to tell you because you're just an employer."

COMMISSIONER HORN: I know he is retired now but David Roy (inaudible).

COMMISSIONER COVINGTON: Yeah, Cathy Rogers replaced him about three years ago but we should bring him back, she might be good to also bring back. That's a good idea.

COMMISSIONER RUBIN: So we're going to identify the speakers from FAP. We're going to let them pick in many ways...I've always found the best way to work with DoD is recognize their military culture. They know best how to...they have a lot of terrific people in DoD and let them kind of run with the data and think eternally and then come back to our Commission with recommendations. I think there's a great opportunity there.

COMMISSIONER COVINGTON: Their current data boys are going to meet with the brass and we're going to talk about what we're doing and we're going to set up another meeting.

COMMISSIONER RUBIN: So eventually this will result in I think at least in one of our meetings or a couple of our meetings, a level of military representation and Family Advocacy representation and make their recommendations to the Commission.

COMMISSIONER HORN: And we have not had that yet?

COMMISSIONER RUBIN: We had. El Paso did a little bit of a local flavor about how they integrated with civilian authorities and they were able to get...they're deaths were principally in military families. Even though there was only 10 percent of their population.

COMMISSIONER PETIT: I think it's a good model the way you're approaching this thing 'cause it does concern me with this and also the Indian one that we will be talking about that we were talking about a little bit, in terms of how much we divert in terms of resources. How much investment of resources are made especially in the military has a very good overview of this and they seem to do know what it is that's going on. Also, think they have only 30 deaths a year

COMMISSIONER COVINGTON: Not at all. 60/70 and that's only the ones they know about.

COMMISSIONER RUBIN: Yeah, I actually think... I would love to see if they announce the national debt index cross with the DNBC file with the military truly understand how many of the kids were dying every year had a parent who was a sponsor in the U.S. Military.

COMMISSIONER COVINGTON: And the reason we know that is because the child death review, the civilian teams that are near bases they do death reviews of kids where they check with the child where the parent was in active duty...and they don't know about those kids.

COMMISSIONER RUBIN: And you're not looking at severe non-fatal injuries. They have a serious issue.

COMMISSIONER COVINGTON: No, I'm talking about fatal.

COMMISSIONER RUBIN: You're talking fatal.

COMMISSIONER PETIT: The number that I have was from four years ago. I'd like to see if 30 was the real number four years ago. If it's 60 today that means it's doubled. So 30 may have not been the figure.

COMMISSIONER COVINGTON: That's the whole counting thing. How they were counting. How they're counting now. Their doing a better hearing about them. To be honest a lot of, I think what's happened is we've worked really closely with them for the last three or four years, actually we started with David is helping them connect where there's a base or an installation. Where there's an installation having them work closely with the child fatality review and they're starting to cross-reference the kids. It doesn't happen everywhere they're finding more kids that way. That's not part of that number went up. I'm not saying that.

COMMISSIONER RUBIN: The severe non-fatal they're not small. So we believe those are the same kids that just, they haven't delivered.

COMMISSIONER COVINGTON: And the issue is related to deployment or depression What I'm hoping they let us do is they're report is finally getting out. They do an annual child fatality review report and it's a closed report, it's not open to the public but I'm hoping they will share it with us. You were there to hear some of it, they have a meeting but you have to be at the meeting and you are told that you really can't share with anyone what you hear at the meeting.

COMMISSIONER RUBIN: Yeah, if they don't know about their kids through FAP they are only finding them through a small portion of the kids through FAP there are fatalities happening to kids out there because they're off base, they don't know about those kids. So I think we've stumbled on to a major area of kids, military families are very mobile they move around a lot so they are very hard to track.

COMMISSIONER COVINGTON: I think in your point, I don't think it's going to be a huge investment of our time.

COMMISSIONER PETIT: The military model might want to apply it to the states. Do this, do that, and you know. Do this do that, delete that that was Wade Horn.

(laughing)

COMMISSIONER COVINGTON: It is really different. (laughing) They can enforce prevention of services with their families. They can say this is what you're going to do.

COMMISSIONER RUBIN: I'll just give you an example an unknown base in North Carolina, so that's 20 percent which will rename nameless but it's very large. (laughing)

COMMISSIONER COVINGTON: You're going to brag about that?

COMMISSIONER RUBIN: I'm not going to brag about it but (laughing) their rates were literally like a democracy. Now it's okay if civilian authorities were on top of all this but you have to know what's going on. So our own program is (inaudible) out work where we're actually going to cross civilian and military data, military child welfare systems mainly in Texas and North Carolina. Actually I understand the full dominator of how many of these kids have had medical diagnosis. Were known to at least one of the two authorities.

COMMISSIONER COVINGTON: And they have a new FAP lead with the Army who is just a dynamo, Tony, Colonel

COMMISSIONER COVINGTON: What's his last name?

COMMISSIONER RUBIN: Colonel Cox. The other thing that there is also a dynamic of secrecy potentially in the military, not very poor because the consequences are so severe for that sponsor. So what may be involved here, you can lose your job and your income. I mean, so this, in terms of how they think about responding and encouraging people to use their resources it's a very tricky issue in the military.

CHAIRMAN SANDERS: All right.

COMMISSIONER MARTIN:] So Marilyn and I have the Native American children, American Indian children. So we have been talking about the scope and one of the, obviously the hardest part is the scope. Within the scope the issues that we're really talking about are the numbers as every subcommittee has said, in addition to not believing the numbers that we have, we have no numbers to really look at to believe. One of the concerns is there's an issue about whether or not the child is an Indian child. Whether or not the tribe has claimed the child. But then it's also an issue about how counts. What consistency are throughout the territories for counting children. There is no like centralized child welfare agency kind of thing on the reservation or anything to count. So the idea is trying to look at something that is consistent throughout the territories to look at what they have in place right now and whether we can add something on to that. Of course, the eye is on all the reservations but we haven't really figured that out. That is something that we're looking at.

The vast diversity among and in between all the tribes is just startling when you really start looking at it. Although I knew it I don't think I really knew it until I started working on this and so that's an issue that's really killing us. One of the issues we heard from Terry Cross yesterday is about the funding and the idea of some direct...and the size, I'm going to try to see if we can get the report that we spoke of yesterday that they've already made some recommendations regarding funding. So I'd like to see that, but one of the issues Marilyn and I

have started talking about is funding on the federal level but also the local level possibility funding it on the local level as well.

We're really in the fact-finding phase. We are planning to go to a conference in April. When we were at the White House, Friday one of the young people there told us about a tribal leadership committee that meets at the White House annually and it's going to meet in November or December and she's going to extend an invitation to us there. The Commission is meeting before Arizona I believe is in March. We are also planning to spend a couple of extra days at the Puma tribe because they've done some real innovative things regarding child welfare within their community and looking at more than anything really organizing how it's done, which is somewhat lacking on a lot of the territories.

There's this whole jurisdiction issue that I never really realized. I kind of knew about it but I don't think I really realized how important it was. So you heard Mr. Cross talk about it yesterday. But one of the things that is intriguing to both of us is how the re-authorization of BAWA handled some of these. Remember so BAWA typically in an Indian tribe when there's a perpetrator of domestic violence and they were non-Indian they were not going to get prosecuted. On the tribe there was a state board issue with the re-authorization of BAWA now if they are non-Indian they can still be prosecuted within the reservation. So there are some exceptions that are being made at a federal level. So we are looking at seeing whether or not we can understand those and whether or not there's an opportunity to make some kind of recommendation about jurisdictional issues so that that doesn't become such a stumbling block.

There was also just the National Indian Tribe Welfare Association report that was released, that we're still reviewing. I don't think we have authority to distribute it yet but we're looking at it to see what's in there. So the issue really for us is trying to figure out what our scope is and one of the things that we're really looking at are numbers, funding issues and jurisdictional issues. And although I think there are a multitude of issues just like in every subcommittee. Right now we're kind of preliminarily trying to focus on those three main issues and see whether or not there's some movement or recommendations that we can make. Or recommendations that have already been made that we can strengthen along those areas.

The one issue David talked about earlier that I've been talking about with David, when we started breaking down in subcommittee's I made a recommendation that we consider a subcommittee for African American children and families. And I think I understand why we didn't have a subcommittee for that group of children and families in foster care but I do think there is still room and there's still an opportunity to really think about the over representation that our country recognizes and experiences with child welfare and as David was saying earlier when he talks about some of the recommendations that he's thinking about or their committee is thinking about with this Public Health model I think it's imperative that all us think about how that does not increase over representation. I'm not sure if I am saying that the right way, but how it recognizes that there's a problem with over representation, you don't add to that problem of what we're representing.

So for instance as we look at the Native American children making certain that any recommendation that we make is not so broad that it brings in kids that don't need to be brought in and brings more attention to the kids that don't need to have more attention. But I do just put that out there but I think there is some room for us to consider that and some need for us really to make certain that is part of our recommendation and a very strong part

of our recommendation. I don't know how that fits but I think it's important for us to let the community know that we are conscious of this problem and we're actively making recommendations that don't contribute to this. So that's what we have which is not, I mean, I guess the most I'm trying to report is where we are in our thinking. But we're certainly looking for recommendations from everyone about what else we should look at. Whether or not these three things that we're looking at namely numbers, jurisdiction and funding are the things that are most pressing and will guide us best or whether or not there's something else that we are missing.

COMMISSIONER BEVAN: With the 535 federally recognized tribes are you limiting yourself to American Indians who are living on reservations?

COMMISSIONER MARTIN: No, I would say no but I will tell you that what we're trying to do is make certain that if we have an opportunity to utilize the reservations to make that a recommendation we will do that. Does that answer your question?

COMMISSIONER BEVAN: Well in terms of counting, how will you count?

COMMISSIONER MARTIN: Well we're trying to figure out a way that we can count all the Native American children. Whether their known to CPS and they're in my state board or whether the tribe has included them in their tribal court.

COMMISSIONER BEVAN: The definition of Indian tribe is and an Indian child is problematic. Especially in terms of membership with a tribe.

COMMISSIONER MARTIN: Well I know. The way it's done in the state court is criminal, almost. I mean, you sit there and you ask somebody and then...and we have a requirement under NICWA that you ask every child if they have Native American blood or if they are related. And then if there's any indication then you have to send this notice...it's ridiculous. It's cumbersome, it's difficult to deal with, and then if the tribe responds getting the tribe involved and how it's involved, it's ridiculous. But the point is I would like to make, this is Pat, I think we're talking about including all Native American children whether or not they are in state board or not in state board. But that goes to the whole issue about who is in an Indian child.

COMMISSIONER PETIT: So the three things that you're looking at numbers, structure, and funding. In my view it's way above our pay grade. You're talking -- you heard him delivery his presentation yesterday on the colonization and going back. This goes way beyond child welfare per say. Just as they did represent yesterday to start with the National figures of fatalities among Indian children was less than the mainstream population. So let's just say it's 2 per 100,000 I don't know if there are 3 million Indians in the country, say 1.5 million are children there's 15 units of 100,000 it's about 30 kids, just as a place to start from. It's not 100 kids, it's not 1000 kids..

COMMISSIONER MARTIN: Okay, assuming that's right.

COMMISSIONER PETIT: Yeah, there's layer after layer on this which you are running in to, it's a sovereign nation and I hope that Teri can say these specific things don't threaten the whole apple cart because it's going to bring in a lot more people in child welfare from the Indian community on this thing it would be helpful to us.

COMMISSIONER RUBIN: He had some great... I was reading through his written testimony yesterday. He had some very specific recommendations about flexibility and funding and access to federal funding and federal grants to do some of the local child welfare work that I thought were very practical.

COMMISSIONER MARTIN: He and a couple of other people, Marilyn, have recommended that we sit down and talk with him. So we're in the process of trying to make certain that we provide an opportunity to do that. So one of the things is to look through his recommendations but also the National Indian Child Welfare Report that just came out. So I'm not sure that we're going to be reinventing the wheel as much as trying to figure out what's the most important. What's going to give us the most traction to get to kids fatalities. But the issue about counting abuse and neglect deaths in Indian country, one of the highest cause of fatality is suicide. So the issue really becomes is that child...are some of those child abuse numbers are not. And so those are the kinds of issues that come in to counting.

COMMISSIONER RUBIN: I wanted to follow up... 'cause the question about disproportionality, should this be a subcommittee just on Native American kids or is it really a subcommittee of racial and ethnic minorities that might include a section on Native American and a section on disproportionality or the African American experience in an unintended harm in terms of preventing unintended harm. Like do you want to expand and maybe that would be a way to be more inclusive. What do you think?

COMMISSIONER MARTIN: If it were up to Pat, I would have a section on over representation. And then we would have portions of that section devoted to Native American children, African American children, military children to the extent that it applies... .

COMMISSIONER BEVAN: I don't think we can assume overrepresentation.

COMMISSIONER MARTIN:Excuse me?

COMMISSIONER BEVAN: I don't want to buy in to racial disproportionality, I think we need to look at the numbers before we can do that. I agree we need to have...we need to include African American children.

COMMISSIONER COVINGTON: Are you saying you don't think they are?

COMMISSIONER BEVAN: I do not believe in racial disproportionality to the extent that some people mean it.. I don't know how, or defining it but if you look at abuse rates and then you look at...I don't know about the abuse rates are higher.

COMMISSIONER PETIT: Fatality rates are tripled.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER BEVAN: I know what you mean by it.

COMMISSIONER MARTIN: What I mean is if there are 2 percent of blacks in the community and there are 30 percent of child protection caseload that's a disproportion.

COMMISSIONER COVINGTON: That's overrepresentation

COMMISSIONER PETIT: It's overrepresentation. But you could, you are not at this point you could but you're not at this point saying that that's inappropriate or not. You're just describing it it's an explanation for what that is. It may be a valid reason. It may not be a valid reason. When you look at the widely disproportion of poverty rates within the African American you'd expect some of the outcomes to be worse.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER RUBIN: I believe in disproportionality, the way that I do, because I think there's pretty good data in terms of biased reporting. I think that if we look at it there's going to be pretty good data around sort of how fatalities are classified across race.

COMMISSIONER COVINGTON: A perfect example looking at infancy sleep deaths, when a suburban mom overlays her baby, oh my God, what a sad story, an accident, or it goes off as SIDS, often times they are even classified as SIDS. When an urban mom in Detroit overlays her baby, she must have been drunk, she must have been high, automatically it's going to be classified as suffocation.

COMMISSIONER MARTIN: And those things matter.

COMMISSIONER BEVAN: Why would you not have look at African American and Native American as a group before we assume, the subcommittee should be Racial Disproportionality.

COMMISSIONER RUBIN: No, no, it would be Racial and Ethnic Minorities.

CHAIRMAN SANDERS: I think though there is a difference in the American Indian population in this conversation. I think there are different issues. Two different issues.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER RUBIN: They are very different experiences.

CHAIRMAN SANDERS: But the issue of sovereignty and the government-to-government discussion we have policy, federal policy that specifically speaks to American Indian children. So I think, I don't have an issue if we think disproportionality or however we want to define it. It should be part of a subcommittee or a separate subcommittee. I just don't think it should be confused with this issue specifically because I think it's a different issue.

COMMISSIONER RODRIGUEZ: I don't think it should be confined to a subcommittee. I think that each of us in our subcommittees should be thinking about the way that our potential recommendations impact.

COMMISSIONER COVINGTON: Or identify within our subcommittee. I think maybe what we all to have to is take a very focus approach in looking at disproportionality or whatever you want to call it within our --

COMMISSIONER RUBIN: I had a conversation with Pat yesterday, for example, I've been talking about the Health Information Exchange for children. It's developing and part of meaningful for use at the state level as part of Health Care reform and what does the Health Care Information Exchange look like for children and I raised should there be child welfare information there so when the kid comes to the ER... and actually I've been chewing on that. Because of this issue of disproportionality because if a physician sees a kid who has been reported and sees the kid with an injury whose mechanism is probably accidental. They are going to perceive, you can end up snowballing this disproportional response. So I think it's not so clear cut that that information should be on an information exchange in terms of privacy. Whereas injury information should be. Like prior injury that has to do with medical.

COMMISSIONER MARTIN: And there's ways to do it, when your friend was talking about yesterday taking hospital data on just the injury. So I think, what I'm asking for is each of us to think about those things within our own subcommittees about how we minimize contributing to it. Does that make sense or not?

CHAIRMAN SANDERS: I mean, particularly subcommittees on kids known and kids not known. That is a specific issue could be to further explored...

COMMISSIONER RUBIN: Wherever confidentiality data sharing exists that has to be on the table. That potential of how do you manage the risk of over reporting or...

COMMISSIONER MARTIN: of unintended consequences.

COMMISSIONER BEVAN: Why now have a subcommittee? I know there's two different issues but either have another subcommittee or something. But it seems that in and of itself it deserves to have...if I'm wrong on disproportionality trust me, there's a lot of people who are wrong on this.

COMMISSIONER MARTIN: No, I understand. I understand what you're saying.

COMMISSIONER BEVAN: In terms of, I want to know...I want to know the numbers and not just the response but I want to know the numbers. The numbers are higher I don't want to lose any kid. Because of some confusion. I don't want people to think hands-off because I'm afraid of the other reports, or the race of the child, I don't want any of that.

CHAIRMAN SANDERS: Why not put it in the two sets that we're looking at the issues--

COMMISSIONER RUBIN: Where does confidentiality and data sharing exists? Is it across subcommittees or is that deserving of its own, or would it live there?

CHAIRMAN SANDERS: We'll talk a little bit at this afternoon's meeting. I think we want to ask some specificity of where we are going to go

COMMISSIONER HORN: So as I understand this subcommittee structure, and I wasn't part of the conversation that established it, maybe it's not, I don't know, it's my view, that the subcommittees are responsible for making the recommendations. The subcommittees are

responsible for gathering information, bringing it to the Commission as a whole and then the Commission as a whole deals with what kind of recommendations will come from it. So in that case I think that these issues are clearly going to come up as a Commission as a whole. And if we think it's relevant in an individual work group, I think that, I agree with you David that there's enough of a difference between this issue and Native Americans that I think there should be a special subcommittee on Native Americans simply because we don't know that much about them. I mean, was...three things stood out yesterday, one is and I was being a little bit cute, because I knew actually which Assistant Secretary actually commissioned this study to enter Native Americans in to NCANDS. (laughing) And I was a little bit surprised that after I left it didn't actually happen. (laughing) but it should be part of NCANDS. In terms of a national study there is no reason why you can't over sample smaller populations and still get ... you just can't do it by having a random sample.

COMMISSIONER COVINGTON: You get the American census survey.

COMMISSIONER HORN: And the third thing was I was stunned to hear him say, I don't know if it's true or not that tribes do not have Child Death Committees.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER COVINGTON: That's not true.

COMMISSIONER HORN: That's what he said. I know the truth. (inaudible - several Commissioners speaking at the same time). So I would encourage you to think, you know, I'm a really concrete guy so I'm thinking about we can solve those, those are really three kind of concrete things we can think about that we can make a real impact on Native Americans.

(inaudible-garbled recording)

Commissioner Bevan: The disproportionate numbers of African American children (are they a disproportionate number, in particular in fatalities?

COMMISSIONER MARTIN: I think so. They're numbers are like three times higher.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER BEVAN: So it would start with that. I mean, that's all I was trying to say. I just didn't want to say it about child welfare because I wanted to start from the beginning. It's clearly something we need to do.

COMMISSIONER MARTIN: So let me ask you. Are you recommending that there be a separate committee on this or what are you recommending?

COMMISSIONER BEVAN: Yes.

COMMISSIONER MARTIN: Okay.

COMMISSIONER BEVAN: Because I think, I think it's a glaring omission if we don't. I do not think that we can handle it all at once). It's too big. It's too big on the field.

COMMISSIONER PETIT: You are recommending there being a subcommittee on disproportionality?

Commissioner Bevan Not on disproportionality. On African American children because of the numbers.

COMMISSIONER COVINGTON: Just like we have with military

COMMISSIONER BEVAN: Yeah, just like we have on..

CHAIRMAN SANDERS: Wouldn't the two committees have to look at this issue?

COMMISSIONER HORN: I think so.

COMMISSIONER COVINGTON: All the committees. Measurement certainly is an issue

CHAIRMAN SANDERS: it seems inescapable that it does come to the whole commission.

COMMISSIONER HORN: You can see how this issue would be important for this Commission.

COMMISSIONER BEVAN: I mean, with the detail look that it requires.

COMMISSIONER HORN: Sure.

COMMISSIONER BEVAN: Would these other committees be able to do that detail look?

COMMISSIONER RUBIN: What we are talking about is to charge the subcommittees

COMMISSIONER PETIT: Whether it's a new subcommittee or not that's all of us. So whether it's six committees or 12 committees it's still 12 of us on this thing. We have a very large (inaudible-garbled recording)

COMMISSIONER RUBIN: I simply would love to see some testimony in terms of...obviously in our groups recessions...there must be folks out there who really are knowledgeable about this disproportionality either in recording or counting deaths or --

COMMISSIONER PETIT: research... There is a lot of work has been done in disproportionality over the last 20 years.

COMMISSIONER MARTIN: But does it really go fatalities? That's what I don't know.

COMMISSIONER COVINGTON: So if you look at NCANDS for 2012 for 2013 reporting. African American the rate per 100,000 was 4.67 for African Americans the rates for American Indians was 2.23 and the rate for whites was 1.6. That's not bad.

COMMISSIONER PETIT: So that's true.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER BEVAN: The code for racial disproportionality, the code in child welfare means a disproportionate number in child welfare.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER MARTIN: Let's just talk about the numbers.

COMMISSIONER BEVAN: The numbers I think have to come out. The Committee can look in a detailed way that it needs to be looked at, if you don't think so then.

COMMISSIONER MARTIN: No, no, no I'm not saying that. So David let me ask you this. Do you know anybody or any work that's been done around the triple number of deaths for black kids in foster care?

COMMISSIONER RUBIN: No

COMMISSIONER PETIT: I don't think so. And the chase that Teri used at some point we looked into the detail of that. So if you just take...take the neglect case around the table, you just go the blunt force trauma, which is higher to mask then the example that you use, it's still triple. So what I don't want to do is get into a misguided egalitarianism when it may well be an explanation for all this. What is the explanation for it?

COMMISSIONER MARTIN: So how do we find out? Who knows where do we go?

COMMISSIONER RUBIN: You've convinced me, that's the reason for a subcommittee. In a population of minors you have this elevated risk in a subgroup.

COMMISSIONER HORN: I'm changing the sign. (interruption)(laughing)

COMMISSIONER RUBIN: If we are going to understand why is it that there (inaudible - several Commissioners speaking at the same time). You are not convincing me with those numbers that there should be a subgroup..

CHAIRMAN SANDERS: And who's on the subcommittee for it?

COMMISSIONER MARTIN: I'll be on the subcommittee.

COMMISSIONER COVINGTON: I would be because I know the data pretty well.

COMMISSIONER MARTIN: You're in three?

COMMISSIONER COVINGTON: I'm going to be done with measurements today.

COMMISSIONER MARTIN: Oh, girl, you're fast.

COMMISSIONER COVINGTON: I don't care.

(inaudible - several Commissioners speaking at the same time).

(laughing)

COMMISSIONER COVINGTON: You guys have so much work. I feel like I'm on...

CHAIRMAN SANDERS: If you two want to bring back information for the next discussion and then we can make a decision. We will make this a more formal ongoing subcommittee or not.

COMMISSIONER BEVAN: Okay, that's fair.

COMMISSIONER RUBIN: (inaudible-garbled recording) testimony it would be helpful for the Commission to try and understand that number.

COMMISSIONER RODRIGUEZ: Because I think that number is probably going to get to that issue around certain interventions. Actually not even reaching some families are not being helpful to some families. I mean, clearly there's families who are at risk who are not getting what they need.

COMMISSIONER MARTIN: Or not known.

COMMISSIONER RUBIN: To me it is how do we began to unpack that hugely elevated number.

COMMISSIONER MARTIN: Let's see if we can find someone who has done some work on this.

COMMISSIONER PETIT: There is some work that's been done on this disproportionality. I don't know if any...

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER BEVAN: Can I just say one thing that's general. This makes me...there's a brain trust over there that's really, really important to this committee and I feel uncomfortable with the kiddie table. I feel uncomfortable (laughing)...no, because it's not fun. And I feel that it's disrespectful in many ways to all of you. I have been on the staff for 20 years. At least I sat behind and I got to turn around and be part of at least the questions and answers during the testimony. But for you to be scattered all over the room and not even be able to hand someone a question that would be relevant and important during hearing the testimony it's a real lack of commitment. Because we're asking some questions that are off the top of the head, you know based on something we just heard when they have read the testimony beforehand and have summarized it and might have some real... probably do have really good questions that we could use and ask and not just the ones to right down but the ones that are involving. So I just would like to recognize how the brain trust there and hope that we can integrate them and have more respect.

COMMISSIONER HORN: I'm just giving them all the work to do.

COMMISSIONER HORN: Yeah.

(laughing)

COMMISSIONER MARTIN: We're letting them, we are giving them questions that they have to research.

CHAIRMAN SANDERS: And I do think that creating of the subcommittee creates a direct relation with staff who are expert in those areas and I think as further conversations occur during the hearing that opportunity will exist. That's part of the idea. To make sure that linkage is there.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER RUBIN: When you're talking about these subcommittees were asked for new data, for example, Public Health needs data on kids across programs. If there is no data on fatalities in terms of understanding the assignment of child abuse and fatalities I'm wondering if there's an opportunity to request data to look at that group of the SIDS versus co-sleeping deaths and look at cross race and how kids are classified. Because that's a pretty powerfully charged statement. So can you actually clearly demonstrate that some of this is a classification versus as homicides.

COMMISSIONER BEVAN: Can I say, having sat in the D.C. child fatality review committee, I can tell you that those terms were thrown around. They were terms of convenience. They were not precise.

COMMISSIONER RUBIN: So we should periodically demonstrate is their current data to demonstrate that SIDS deaths are being classified differently

COMMISSIONER MARTIN: Let me play the devil's advocate. Let's say we find out that there is evidence to support that statement, the SIDS deaths. What do we do about it? Why is it important for us to know?

COMMISSIONER RUBIN: Because I think it gets a little bit to the question of how much that 4.67 is real and how much of it may be a little may be a bit a part of truth sort of a differential handling of the way cases are classified.

COMMISSIONER PETIT: But David the 4.67 is real what may not be real is the white classification. So I don't want to end up understating in a sense of egalitarianism. The main question is following what the numbers show us. I don't believe that any of the black homicides are the result of a DNA situation. It's a manufactured behavior. I think poverty and the history of the black community is such that it produces the kinds of circumstances that we're seeing up here. On this particular piece if you can do a measurement on safe sleep with this other stuff, great. If you can actually calculate that. But on the blunt force one I don't...do you think the classifications are there?

COMMISSIONER COVINGTON: I don't know. I don't know.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER BEVAN: It's really important because if white families are disproportionately being labeled SIDS cases then our job is to make child fatalities, make awareness of child fatalities and take things more seriously then we have to be very clear about who fits in what category and what to do about it. The response is different.

CHAIRMAN SANDERS: So we have one more...we don't actually have a formal subcommittee but we had talked about giving Amy's expertise in communication that we would have some conversation about that and also from your point Cassie I think my staff did a great job in putting together a media plan so we're going to talk a little bit about that and get a sense of where we want to go with the plan that's been proposed.

COMMISSIONER AYOUB: I hope this causes deflection into this conversation. Jennifer and Trisha and Derrick have created and developed a very comprehensive media plan and it would make my job very easy because it's something that's going to take us forward in a way that I think I mentioned is working to deal with the media. They've built an extensive list of media contacts and I think we've seen the media more just attached to the meetings that we're having. The media outreach, some of you I think have been interviewed, I think you have been interviewed, Michael? But there's a plan to do even more than that to have some outreach in between the meetings on different topics. So maybe there's some best practices that can be shared. The importance of the accurate counting. The urgency of this issue. Things like that. There's also strategies for some odd pieces that they're working with the GSA legal team right now. So they have some great ideas but they're going to make sure that it matches what we can do legally.

The hope and the goal of the plan is to engage the Commissioners as much as possible. That they've had the training, that they had...have you done one-on-one with some? I know you haven't with all but there will be one-on-one opportunities to have some mock interviews training too. Whoever is interested in that. But they have that tool kit that they sent out the does and don'ts for the media, Webinar training. There are some opportunities for some of the Commissioners to be included in an editorial board meeting and also when there's breaking news, if there is something specifically in your state, maybe be with someone there, so that we can be included in that.

There's another section of the report, to watch the report, the internal report and finally a report strategy. And then one piece of it of course, we've talked about it before is the social media piece. And that's why I wanted to take a little bit of time today to see what everyone's comfort level is. Who wants to participating in that. So at this point there isn't a Facebook page or anything but that is a plan. To be active on Facebook, Twitter, YouTube and it's very important as we've talked about to reach out to other organizations and other advocates that we're going to need to support us. Social media is one of the key ways to do that. They're building an extensive list of organizations to be included in that. So there's easy things that we can do just to get the name out there, the word out there. Eventually we'll get the social media pages setup the blog that Chairman Sanders is writing now can be shared on there, the meeting announcements and , some of us have been, when Patricia sent out the announcement, we put that on our Facebook page. I don't know if all of you have done that. I Facebooked that out and Twitted out. So whoever...it's already active out there those are little things that you can do. But then eventually hopefully there can be things that they can set up that maybe out of the meeting there is something that came out that was interesting that they can send us what to say and we can just put that out there.

Also, there's opportunity to write a blog. Again, we just want you to think of any way that you want to participate that's what the committee wants. That's what the media team wanted. And if we could go around the table and just tell us, if you are already active on social media and if you are interested in being included in any of the ways that you can help us to get the word out through social media. Jennifer?

COMMISSIONER RODRIGUEZ: I'm on Facebook and.... I have my own personal Facebook page and I co-administer my organization's Facebook page. I refuse to Twit although I do follow quietly a couple of other people. (laughing) It's an egotistical thing to me like I don't think I have anything in life that's that important to Twit out to people about.

Commissioner Sanders: And I will say, and maybe someone from the media can give me numbers but a lot of people get their news off of Twitter.

COMMISSIONER RODRIGUEZ: I follow a couple. I mean, I know how to use Twitter. I'd be happy to help with it if there are things that...but I'm not going to start Twitting my own personal stuff just to have. I don't do the selfies. I don't do the food picture.

COMMISSIONER AYOUB: The other thing that can be done there can be a Twitter handle that is for the Commission. That it is used by the Commission that they can setup and so it would just be used for that if you're willing to do that.

COMMISSIONER COVINGTON: One example of Twitter being, you're in Portland and you meet with Terry Cross ...

COMMISSIONER RODRIGUEZ: What you'd want to do is all day yesterday during the testimony like little key things wherever you had a moment where you were like, oh that's interesting you would Twit out like, "tribes not getting CAPTA money, what a shame," hashtag.

COMMISSIONER HORN: Can I say something here?

COMMISSIONER RODRIGUEZ: I'm just saying like that would be an example of the way that you would use Twitter.

COMMISSIONER AYOUB: Our goal would be to be positive and not to just insight negative comments back. Because social media is really open, it's really a way to get a lot of -- (inaudible - several Commissioners speaking at the same time). So the point would be to be something positive. Everybody knows that negativity is going to come on articles that are written. There's places for comments. On social media there's...if it's inappropriate it can be deleted. We can't avoid the negative because there's a lot of positive that can come from that. And what we're trying to go is make sure that when we're giving this report that we have all the support we need. The 12 of us are not going to be enough. We want all the support. You don't want people saying we didn't know about that or why didn't you tell us about this or that. And it's hard. Without the social media nowadays it's hard to get the word out. So we understand the negative that can come from it but the positive is going to outweigh that and whatever...when you ask what would you Twit out, it would be something that is fed to us from the team so that it's consistent and it's positive.

(laughing)

COMMISSIONER HORN: I say it's really important that we have a plan. I think it's really important that once the report is issued that we have a plan in place to present that information out in a very aggressive way. I think it's too premature for us to do anything more

than, in my opinion, at this point, then to have...notify the press that we're having public hearings, have the press attend it and they cover it. Have a few people that talk about what the mission of the Commission is). It makes me very nervous at this point for us to be talking about subjects and issues as process issues when we have not come anywhere close to consensus on what it is that we want to say as a Commission.

COMMISSIONER RUBIN: One thing that I do feel comfortable with so I mentioned our Senator sent out a Twit yesterday it was basically a Twit that said, it was a photograph of Joanne Wood testifying and it said, "Dr. Joanne Wood testifying on" if it's done right you can then link to that's person work, not to our work, it's more about elevating consciousness about the issue. So I do think there's a strategy not to get out ahead where you might use some of the social media space during the public meetings to actually elevate the speakers who are before us not our people. So allow them to link to their works of people who are following the Commission can link to Terry Cross' work. It's no representation of our feeling about that work. It's sort of like, so-and-so testifying on Native American issues, see his work here.

COMMISSIONER AYOUB: And when they do have articles that we put that out so there's local articles here but they don't make it to the other cities. We can put that on our page and individuals can share that on their page and their cities. It's a public article that was already written.

COMMISSIONER HORN: I do not agree with everything that everybody is saying that is testifying before us.

COMMISSIONER BEVAN: Right, we have to say, this is not represented.

COMMISSIONER HORN: So if, it's perfectly fine if each individual wants to, it's a free country. Do what you want to do, it makes me really nervous when we're talking about representing the Commission as a whole. That's my objection at this point.

COMMISSIONER AYOUB: Again, I would say and I totally get that. We would have to be very careful. I do think that websites are useless if you don't draw people to it. Nobody knows how to get there. So social media also is a way to draw people to our website. So for the blog the Chairman is writing that is something that obviously that would be (inaudible-garbled recording).

COMMISSIONER HORN: I will not participate in this. I think it's too premature. I think that in arms position before, potentially harms position before we have a chance to deliberate on them and I'm not going to object to it...if the rest of the Commission is comfortable it's fine with me and I would be very happy to participate. And I would very happy to participate, in a very aggressive media strategy once we have a rapport and we have it because we have achieved a consensus report. This is not an anti-media statement, which is why I preface by saying that. I think it's real important we have that developed and ready to go. I'm just worried that we're too far ahead of ourselves right now.

COMMISSIONER AYOUB: Okay. I disagree. Again, I do think, I actually I do get what you are saying, you have to be careful but I think that in order to have engagement...it's not just media that's getting the engagement of all of the stakeholders we need to have some social media strategy there to reach out to them.

COMMISSIONER COVINGTON: So that people at least know what we're doing?

COMMISSIONER AYOUB: Yes. Even announcements of meetings. Just to have a page where...people automatically go to Facebook when they hear about a mixer and there's not a page. So just to begin with, what I was talking about is in the future, so to begin with just have the basic information that there's a Facebook page, there's Twitter handle that can be...and there can be notifications about the meetings so it's easier, instead of us posting it we can just share it from that page.

COMMISSIONER HORN: That's what we are talking about

COMMISSIONER AYOUB: And then there is the blog, the Chairman blog that leads back to the website. Anything that's already on the website that we can link back to the website, then you can get public comment on the website. Nobody's going to the website because they don't know about the website. You have to get the word out there about it. So that would be the basic.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER RUBIN: If you don't take a cherry picking approach and even before the meetings send out...like to me it's part of advertising the Commission group. Here's who testified. So if you don't cherry pick those people it's not...I also hear your opinion, which is we could take a silence and just advertise the meetings. I'm not actually going on in this issue. (inaudible-garbled recording)

COMMISSIONER HORN: And I apologize for my opinion.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER PETIT: Nobody should be apologizing for their opinion on anything. I think what you're talking about in a more neutral tone by the Commission per say. And I think the substance of aspects, what we're doing by itself is sufficiently provocative. What you're talking about is setting it up so that at some point people will react and feel more strongly and more supportively of what it is we are. I start from the premise that we are child advocate, so it's all the staff that's why they were hired on this thing. So it isn't a question of philosophy in this case it's a question of tactics and strategy for getting the big thing. So I've got like three things that I've mentioned before that I think fit what we're talking about.

One, is identifying the 25, 35, 55 or 150 national organizations that do have an interest in this topic. What we talked about is in each single case making an over trip to their communications people and just relaying to their networks what it is that we're talking about. Now if you do what I have said on that the number of people, how many degrees of separation are there amongst all these groups? You are reaching a large part of the country when the Women's Federated Garden Club who she was who she was talking about yesterday they have big supporters of stopping child abuse and neglect. They've actually been listed, they're on our project lists and they have five more numbers than the National Association of Social Workers. So one thing is that very systematic thing in which Patricia or Liz or somebody says it was 150, here's the checklist of where we are. Eighty-five of them, they relayed the message, they've rewritten it, so that's one important thing.

A second piece on this one is there are certain media that we know serve as stocking horses or serve as leaders upon which other media builds. The New York Times is one of them per example. The New Yorker is another one. Diane Rehm is another one. The approach is how do you make Diane Rehm move at least it was for last five years on this issue. We don't think our readers are going to be interested in this. I mean, listen to Diane Rehm for Christ sake, they cover beheadings, they cover every topic in the world and some associate producer says, "we don't think our listeners will be," so I would say to Liz or David or me, go back 50 times until they finally say yes. The New Yorker is another one. There's a series of publications that we really need to solicit and see if we can position. Last week at the White House I raised an issue to Roy Austin who is the Deputy for the Domestic Policy Council about why not the president in 2016 host a national conference to distribute this information. Then would it get some recognition? Then would it get noticed by the public? Of course it would. That would be the culmination. If we could get the president and members of Congress a bipartisan group that says, "this is a serious issue and we're going to stop this", "we are glad you 300 people are in the White House today"

COMMISSIONER COVINGTON: 234

COMMISSIONER PETIT: Yeah, whatever that is but they said it would (inaudible-garbled recording). But my point is a building block process that culminates into a larger thing and it would harness or at least be neutral in our town, other than saying, we're not neutral in the need to protect our children and stop them from dying. That's our basic position and each week we're getting stuff sufficiently interesting that as you said, it could be promoted. I don't know why we don't do press conferences at the site of each one of these things. I think that would be --

COMMISSIONER RUBIN: I've seen a dwindling number of people and interest locally as we've gone across. So to me part of the strategy if you're going to use social media it's not about opinion it's how do you use the advance, whether it's the local groups or whatever and be able to use your social media strategy just to advertise we're having a meeting, the types of things we're discussing and maybe we will get a larger audience, a larger level of interests and let the strategy that allows the local community kind of build some momentum on this issue.

COMMISSIONER PETIT: And in four weeks we may have some nationwide associated press story, multi-pod series on child fatalities. They may run it for a few days. And if it's CAP it will be in every jurisdiction of the country. So at that point what can we do in reaction?

(inaudible-garbled recording)

COMMISSIONER RUBIN: So would you agree that you could come up with strategies to even increase that?

Female Staffer: Oh, we are. (inaudible - several Commissioners speaking at the same time). Our numbers have been increasing (inaudible-garbled recording)

COMMISSIONER AYOUB: It didn't look like it. I'm glad to hear that because it didn't look like it. San Antonio looked compared to the next meeting.

Patricia Brincefield: Actually we had twice as many people have been following us. Now, it's not just, it's people on the phone too (inaudible-garbled recording)

COMMISSIONER AYOUB: We don't know how many that is?

Patricia Brincefield: Well we know how many people registered.

COMMISSIONER AYOUB: I'm saying we didn't know. So what we're saying is what's in the room? That would be great to know.

COMMISSIONER PETIT: Patricia each day with child welfare in the news we get 20, 30 stories, they all have a byline, and one of the things we talked about is everyone of them, every day that they print something should be notified that we just had a meeting, here's who spoke, et cetera, et cetera. Are we doing that?

ELIZABETH OPPENHEIM: We are doing that.

Commissioners Petit: We are doing that? Good.

CHAIRMAN SANDERS: We probably need to finish in just a second and break. So do you want to continue around or do you --

COMMISSIONER AYOUB: No, I don't. But if everyone would let Jennifer know who wants to participate when it gets to that point. We don't have to go around. (inaudible - several Commissioners speaking at the same time) There's some blue ribbon committees (inaudible-garbled recording) that you're reaching out I've heard some blue ribbon committees and I just wanted to point out that Las Vegas...Nevada has just created a blue ribbon committee that was created by our Supreme Court Justice, Nancy Saitta and has some...because of some things that have been happening right after they created that there was a death of a child who was in foster care. So that's really --

Commissioner Female: This is a new blue ribbon one?

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER AYOUB: Within the last month the blue ribbon... (inaudible - several Commissioners speaking at the same time) (laughing) There was a new blue ribbon committee formed by Supreme Court Justice Nancy Saitta within the last month. Within the last couple of weeks a child was killed from a foster parent. So that raised the visibility even more and today there was an article (inaudible-garbled recording) Congresswoman Saitta has given her federal support of any resources that will help support that blue ribbon committee. And they mentioned me as a resource being on the Commission, so that can happen in any of your states when...whoever appointed you. It mentioned also, so I'd love to also make sure that we get...that if somebody is mentioned that's on this Commission as a member of the Commission, not that they're just mentioned in the press for something else, but that that's all shared because we might be asked about that. You might be asked in your state about the blue ribbon committee in Las Vegas that we just formed. So I hope that can also be a resource to any of you working on committees.

COMMISSIONER PETIT: Proactively on that. If everybody is taking a look in the news I bet there are 10 or 15 or even 20 states right now where there is something like a Blue Ribbon...

COMMISSIONER AYOUB: San Antonio mentioned they have

COMMISSIONER PETIT: There is Florida, there is South Carolina, they are all over the place 'cause this isn't working. So I think one of the things that as we and maybe you guys have done this already Jennifer, is make an overture to the press in those states where there is this kind of a governor's level or supreme court justice or legislative blue ribbon panel and ask them to plug in to...by the way there's a national commission as well on this piece. And we ought to classify anyway how many of those states are under that kind of duress.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER PETIT: But if we went through the news and said Commission and the state you'd get a lot of them right away and we would reinforce the fact that child protection is a system in crisis.

COMMISSIONER AYOUB: And the final thing I'll say is that the staff is also looking at it's not just a one-way thing but how the media can help bring us information and maybe testify about what happened to us in Florida.

COMMISSIONER HORN: I was not aware that David had a blog. That's a serious statement. That's a problem

COMMISSIONER AYOUB: Social media is a problem.

COMMISSIONER HORN: I have no idea what the blog says. I don't think that should be happening.

COMMISSIONER PETIT: Because?

COMMISSIONER HORN: That I don't even know if you're ready to blog? Why should a Commissioner not know that the Chairman of the Commission is writing a blog about the Commission's work?. No one has ever told me this. How could it be?

COMMISSIONER AYOUB: It's on the website.

CHAIRMAN SANDERS: It's on the website so, which probably suggests that we need to do something to indicate that information that is on the website is there. I think that's the assumption is that we've made that at least internally we look at the website but that is obviously an over assumption.

COMMISSIONER AYOUB: Maybe also it can be proactive when there's a new blog written that it's sent out. It's so easy to send out the link.

COMMISSIONER HORN: That's something that I should not be surprised.

CHAIRMAN SANDERS: It summarizes an issue from the previous meeting. It's factual information from a previous meeting. So there would be blog on this meeting in Vermont. Maybe talk about the content included, helping prevention or safety risk assessments.

COMMISSIONER PETIT: So it's not an opinion blog you're basically keeping people posted on the developments?

COMMISSIONER COVINGTON: That means I have to go to the website I supposed I could be a big girl and go do. But another easier thought would be if we do it the staff can email it to us.

CHAIRMAN SANDERS: This is not meant to be secretive I think the assumption that's in that the website was something that we were using and I don't believe that we should not be doing. It seems like that's obviously been a big assumption that we should not be doing.

(inaudible - several Commissioners speaking at the same time).

CHAIRMAN SANDERS: Why don't we take a break.

(inaudible - several Commissioners speaking at the same time).

FRIDAY MORNING BREAK

(inaudible - several Commissioners speaking at the same time)

COMMISSIONER BEVAN: We've waited a long time Wade, Bob, Hope, Marcie and Derrick whose name is not on this but should have been because we made a mistake. But this a policy/intergovernmental subcommittee and what we see ourselves as task to do overlaps with all other subcommittees. So we overlap and we will try to take what you're recommendations are and see what policies fit your recommendations. Doesn't mean that we will approve your recommendations, negate your recommendations, we just want to see where they would fit on the federal, state or (phone interruption).

So what we will try and do is work with all the subcommittees to the extent that we can and we will put a policy then on issues that emerge. We want to bridge the gap between research policy and practice. We want to be able to help subcommittees do that. We also want to extend our relationships across the cross-sectors so we can reach out and again have a goodness of fit between where we are in terms of recommendations or interest areas and the real worker. How this would function in the real world. And how we can make it real, viable, give it legs and have it blossom.

So we need to work together to facilitate intra-commission strategies so that we can work together on everyone's subcommittee, so we can fit in to the extent we can help with identifying what services, what barriers risk factors, data collection We are the subcommittee that wants to tell a story that hasn't been told. We want to wrap it into a story. Because that's part of what we think we should be doing so we want to look also at to make sure that you are looking at our charge. We are very mindful of what we're required to do. Effectiveness, ineffectiveness...the statements that are in the statute that we have to fulfill we see our policy committee as being very focused on the mandate. And then we want play an active role in the governmental and cross-sector outreach. So we would like to focus

on a variety of stake holders. MGA and CFL and NACO, Administration Congress, in order to proactively see how we can take out the recommendations that we're hearing or the interest that we hear and drive it back up into a federal policy, a state policy for what the mission or principles or releases or from let's to say NGA. Did you all file with the state?

COMMISSIONER HORN: I have a problem with everything you said. (inaudible-garbled recording) (laughing)

COMMISSIONER BEVAN: So that's what we're trying to do. So we hope that we can work together. We will contact all of you and hope that we can...we'll send you whatever draft we can come up with and you can send us whenever you'd like to if you want. And we want it transparent so that as we work we either hold conference calls or we send out stuff but we want to be very transparent. Obviously we have to be transparent.

COMMISSIONER RUBIN: Cassie, one of the things I was hoping you guys could help me with is...we're hearing a lot of interest around flexibility and child welfare, financial report but we haven't had any specific testimony about locating some of the thought leaders on what that might be look like.

COMMISSIONER BEVAN: We can do that.

COMMISSIONER RUBIN: That would be helpful.

COMMISSIONER BEVAN: David, we have a whole group on that.

COMMISSIONER PETIT: At this point, as you said earlier we're not recommendations. We're beyond recommendations. I just want to show what the debate is. Because (inaudible - several Commissioners speaking at the same time) there are very sharp divisions about this issue.

COMMISSIONER RUBIN: I'd like to see both of those sharp divisions and have a (inaudible - several Commissioners speaking at the same time). I'd like to understand a little but what the debate is. I felt like we got a pretty unanimous from the DHS level every state has flexibility (inaudible-garbled recording).

Commissioner Male: Is there anyone in America who doesn't want flexibility?

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER BEVAN: You can look at flexibility and you can look as giving up an open ended entitlement.

COMMISSIONER RUBIN: Right. That's right.

Commissioner Male: I was surprised by this. (In the context 32 states are either operating currently or have an obligation to operate under a flexible funding wave

COMMISSIONER PETIT: Most of those 32 states are vulnerable to a successful Class Action Litigation. So the mere fact --

CHAIRMAN SANDERS: Really 23.

COMMISSIONER PETIT: So the mere fact that they have bright ideas about flexibility doesn't deny the fact that they're overall system (inaudible-background noise). I'm just making the statement. I know the states want flexibility. We also want them to uphold federal law.

(inaudible - several Commissioners speaking at the same time).

CHAIRMAN SANDERS: Question. Maybe it's a question for you Wade but a question because it does seem that Michel has touched on this but it does seem now for the first time more money is being put in at the state and local level then federal law and so in thinking about policy do we really focus on the 48 percent or the 47 percent that's federal and do we focus on 53 percent that's state and local? How do we think about that?

COMMISSIONER HORN: Their terms or our terms?

CHAIRMAN SANDERS: In terms of something specific. Something like counting. We just talked about the number of states that have Commissions or whatever. It seems that there's an opportunity for states to test some of these ideas out or there's an opportunity for Congress to say, "This is not a way to count this." It seems like we would be better with the former at least as an initial step. That's kind of a question because our charge is not so much to impact state policy as it is federal.

COMMISSIONER PETIT: So I would say on that at this point that it isn't our role to say what the respective percentage should be by the states and the federal government. What our role is...here's what it would cost. So we're not starting a revenue increase we are not starting a revenue decrease what we're saying is that something needs to be happy to support these kinds of things. There are states who do it differently, some states spend two, three or four times more per capita than other states. So my point is I think it would get a complex not easily resolvable situation. (inaudible-garbled recording) .

CHAIRMAN SANDERS: I'm not speaking of the money as much as the fact that now this really is a state and local issue more than a federal issue as it relates to funding the system. How do we attend to that? It could be that our focus is entirely on federal policy. But in this area I am saying do we want to have pilots that we encourage versus federal policy.

COMMISSIONER BEVAN: Well in the requirement, Number B, it states that, "a study of the effectiveness of federal, state and local policies and systems within such services" so we have to look at that. And I do think that we're...we're of the thousand flowers bloom philosophy but -- (laughing).

COMMISSIONER PETIT: But on that point you've got some states that have much higher per cap income. They are more easily able to catch themselves in providing services. Some states that have much lower per cap income and much more poverty and they don't fund as well and that's the reason why the federal government jumps into some of these.

COMMISSIONER BEVAN: Right and that's why the match is is the Medicaid match from anywhere from 50% to 8..

COMMISSIONER HORN: So we have heard a lot about from local agencies, state agencies, about flexible funding I think that the point that you're making David is a very valid one and I think we'd agree with this is, I'm not sure that, except for a small group of us around this table who have been immersed in this for 25 years understand that the landscape of what that is. So it's not our job as a subcommittee to make a recommendation. It's to heightened the issue and to put as fair an objective a report back to the Commission as a whole of what the issues are related to it and then the Commission will debate grade it.

COMMISSIONER RUBIN: And maybe bring a couple of good speakers to help develop for future meetings.

COMMISSIONER MARTIN: That's not something that (inaudible).

COMMISSIONER HORN: I'm sneaky.

(laughing)

COMMISSIONER PETIT: This issue when we get down to federal and state level is where the the rubber will meet the road. But we are not there yet.

COMMISSIONER RUBIN: Obviously it's a personal opinion. I think we have an opportunity as a Commission to do something bold about child welfare, the financing. What that will be I don't know. But I think that if we want to take bold steps and the idea of moving upstream and some of the problems with the look back and all this other stuff that I want us to deliberate on that. We're going to make some outside the box recommendations the Commission would seem like it would be able to do it.

COMMISSIONER HORN: You know, David earlier, in fact, the very first meeting, there was a whole review of federal funding streams which I think we might want to revisit that now that there's a broader, sort of like...we're not quite sort of difference in terms of backgrounds in some of these areas. So understanding what the federal funding things are, what they do, how they can be used, how they can't be used, that might be useful to do again at some point. I don't know.

(inaudible - several Commissioners speaking at the same time).

CHAIRMAN SANDERS: I can't see. Is Hope here?

COMMISSIONER BEVAN: Yes, Hope is here

CHAIRMAN SANDERS: I know she's done a lot of work with Marci.

COMMISSIONER BEVAN: Hope has done this.

CHAIRMAN SANDERS: . It would be good to repeat it I think with the additional information.

COMMISSIONER RUBIN: The other thing I think the representation on this Commission is so good and bipartisan that if we could actually agree on recommendation that people would take it seriously.

COMMISSIONER MARTIN: That's a big IF. (laughing)

COMMISSIONER HORN: Some of us have been on opposite sides of some of these issues for a long time. Our positions are hard. But one of the advantages of other people is they bring a fresh look to it.

COMMISSIONER COVINGTON: It is all about the children. (laughing)

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER PETIT: Every child has it not just most of them or probably everyone. But everyone.

(laughing)

(inaudible - side conversations and several Commissioners speaking at the same time).

CHAIRMAN SANDERS: So let's...Teri?

COMMISSIONER COVINGTON: Yes, I'm supposed to make that presentation.

CHAIRMAN SANDERS: We've heard a lot about child fatality review and the process so what we thought would be helpful and Rachel has also done a lot of work on this. To just provide something actual about how many states are doing this, what this looks like as we go into the discussion this afternoon on counting. So this is not the point that recommendations are being made it really is just factually what's going on but will be used kind of the platform for this afternoon.

(inaudible - Side conversations and several Commissioners speaking at the same time).

COMMISSIONER COVINGTON: We were actually going to make this presentation part of the afternoon but because I have to leave at 1:30 we couldn't do that plus then present sort of our summary on what we've learned about measurement. As you all now we're trying to make measurement out on an early what is the word?. We're trying to get measurement out of the way if that can possibly happen. For the afternoon public session we're going to summarize what we've done on measurement kind of quickly and what we've learned from all of our presenters. Present and summarize in terms of what their recommendations have been that we've heard from the field and there's actually a copy that Rachel put together in a written summary for you. I'm going to do a quick presentation for the public session sort of summarizing this and then we're going to get into some deliberations about what we would want to do in terms of our recommendations.

So when we're presenting these responses it's going to be just that without me putting any of my own ideas in this. It will start at 12:45. So I guess one thing that I'd ask that everybody make sure they're there at 12:45. Oh, good. That's great for me. I've got to go. (inaudible-side conversation and garbled recording) I have eight brothers and sisters that are already there and they're wondering why I'm not.

We want a lot about child death review in terms of one of the ways these cases get measured and discuss and then there's been a lot of questions from Commissioners through emails asking

what child death review is. So we thought we would give you a quick one, two, three on what child death review is because it's becoming increasingly more complex. So since 2002 I've been managing the National Child Death Review Research Center. We support the states and their death reviews, standardized practice so this is sort of an overview. Very factual overview of what's going on in the national child death review. And this is a really noisy slide. I don't need you to read it but I will point out a couple of things which is in the early years child death review sprung up from local teams and that 1990 Missouri published a paper on pediatrics called the Under Ascertainment of Child Fatalities on child abuse and fatalities. They basically proved that they were missing about 30 percent of fatalities due to abuse and neglect and they were classifying them as accidents and other things. That led to the state of Missouri passing a law of within a year that they had to do comprehensive, multidisciplinary case reviews at the county level for all children under the age of 14. They had to establish five forensic pathology centers in the state and all child deaths under the age of four had to be investigated by a forensic pathologist. And that sort of set the standard for how everybody else started working.

The child death review really percolated from a local level up. States starting building teams. And then the feds got a little bit more involved so the Department of Justice...OJJDP ending up funding the National Training Teleconference based on some of the local experiences. And they also funded another national meeting in the 90's. And then a lot of groups started saying, "Well, if you're doing all these reviews why don't we make them...why don't we start reviewing all preventable child deaths." If we review all preventable child deaths, you're going to find more maltreatment and you're actually going to have an impact on preventable child deaths. That came out of the Public Health Agreement with the Maternal and Child Health Bureau (inaudible-garbled recording).

The Children's Bureau funded the national meeting and they worked together with DOJ on some of the funding for early work on child death review but no one's every provided direct funds to states to the child death review. But the Children's Bureau did allow states to use their OJJ or their CAPTA dollars and their CJA dollars. They sort of encouraged it informally that they could use those dollars to help establish and manage teams, and a number of states have I'll show you in a minute.

The other big thing that happened in '96 is that CAPTA authorized that citizens review panels had to be established. And I'll talk more about that but one of them had to...every state was supposed to have three panels at a minimum and one of those was supposed to work with child abuse and fatalities. And I'll talk about how states sort of have dealt with that CAPTA piece.. We were funded in 2002. That's sort of a quick brief history. So really after the Children's Bureau quit funding their sort of national technical assistance training, which was a national league, they haven't done anything to fund it other than allow states to use CJA and CAPTA dollars for their state teams. The only other funding nationally has come from the Maternal Child Health Bureau which funds our research center at (inaudible-garbled recording) dollars a year and that's pretty much all that you're seeing in federal dollars to support child abuse.

What's happening in the country is that every state has what we call a multi-agency prevention focus review. And those are either...I know I'm going into more detail, I know, but that's pretty much the classic child death review model that I'll talk about.

Then we also have 14 states that are now doing this new thing called these multi-agency child welfare systems reviews and some of them are using them and calling them citizen review panels but the recent trait has been to actually legislate these and they usually get legislated when there's been a real high profile child fatality case. Most recently that's happened in Tennessee, Kentucky, South Carolina is probably going to be there real quick. Oklahoma, did it...those are the real --

COMMISSIONER HORN: Can I ask you a question?

COMMISSIONER COVINGTON: Yeah.

COMMISSIONER HORN: Are the multi-agency different...?

COMMISSIONER COVINGTON: Different from the child welfare? Yeah.

COMMISSIONER HORN: So it's not that they just expanded it. It's the same thing.

COMMISSIONER COVINGTON: No, no they actually created. So, for example, in Tennessee now they have a child fatality review program and a child death review program. The child death review program is being run by social services to look at deaths of kids known to the system. The child death review system is operated on a public health and they're in every county and very involved deaths. They're reviewing the same cases. They're not talking to each other. This is a new phenomenon. We've been spending a lot of time trying to help states, at least talk to each other. Those 14 panels typically are legislated from the state that gets ticketed off when they see a bad case.

Then 28 states are also doing child welfare system reviews often just using, for example, agency staff and maybe bringing in law enforcement or what have you. They are a little bit smaller reviews. They're not as...they're not real vocal and verbal, they're kind of quietly looking at their own systems problems.

COMMISSIONER RODRIGUEZ: And those are in response to a fatality as well?

COMMISSIONER COVINGTON: Not typically, no. They've just been around for a long time.

COMMISSIONER RODRIGUEZ: What would be an example of like of the name? Would it be a commission?

COMMISSIONER COVINGTON: Colorado, I'll show you Colorado. I'm going to read an example of Colorado. So, Colorado at the local and the regional child welfare offices have to review when a kid is known to the system who dies. And they do that in addition to having county based multi-agency prevention agencies. So there's a lot of reviews.

COMMISSIONER RODRIGUEZ: So they are in response to a fatality

COMMISSIONER COVINGTON: Oh, yeah, when a child...I thought you meant in response to a real publicized case

COMMISSIONER RODRIGUEZ: I meant with that third layer. Is it a system review or is it in response to a fatality.

COMMISSIONER COVINGTON: No they only review when there's been a fatality and the kid's known to the system. Then pretty much every child welfare agency is doing internal reviews. We look at agencies for compliance issues, that are more private. They're not publicized. That's where they get into a lot of issue about worker performance, and et cetera, did we follow the right protocols and procedures. You would think we all know something by now. What I do know is that we've created standards for the blue top bar on how to do those reviews and we try to help the green and the yellow bar learn how to do systemized reviews. But a lot of places are not real interested in...they're just doing their own thing. They're not real interested in having somebody to say, "here's a model, here's how you want to do this." They are all over the map and I don't think they do them very well. Because they are not doing them systematically. That's my own opinion.

COMMISSIONER HORN: Where is the data for that?

COMMISSIONER COVINGTON: That was an opinion. Sorry, no opinions allowed. (laughing) These are the kinds of death reviews...so the blue bars...we're looking in the U.S. about 25,000 preventable deaths a year. There's about 60,000 total deaths in the U.S. every year. The other part of that are prenatal deaths, which I'd actually include considering a lot of those as preventable and then medical deaths. So teens in general are looking at about 25,000 deaths a year. I don't know what the deaths are that are being viewed by the green bar. I know that the deaths known to CPS tend to be about 2,500. Deaths that with an open CPS I don't know what those numbers are. And then the purpose of the reviews --

COMMISSIONER PETIT: Excuse me...you said deaths known to CPS are 2,500 a year?

COMMISSIONER COVINGTON: Yeah, sort of and I took that off of NCANDS as a rough estimate. That's a rough estimate.

COMMISSIONER PETIT: Well, they're saying that they... that there are 1,700 a year.

COMMISSIONER COVINGTON: Yeah, I added in a couple. I can show you how I came up with that number.

COMMISSIONER PETIT: No that's fine. That's not the NCANDS numbers. We've been using that number ourselves at the coalition, saying somewhere above 2,500.

COMMISSIONER COVINGTON: The GAO came up with that estimate.

COMMISSIONER RUBIN: Just how many kids are just non-classified. I remember this one case we'd go a sudden unexplained death we don't know yet. And the kid had as a baby an old femur fracture. But it was an old femur fracture and so they still classified it as sort of either undetermined or...and I was like, "Well, you have an old femur fracture on a kid who died suddenly...that sounds like suspicious child abuse or neglect..." because they really couldn't apply it on the old femur fracture so they still classified it as either undetermined or pneumonia. And I'm like, "the kid has an old femur fracture, on a kid that died suddenly. That sounds like suspicion for child abuse and neglect. But because they couldn't classify it in (inaudible-garbled recording). That happens, I imagine, pretty regularly among those 25,000.

COMMISSIONER COVINGTON: That is a lot. The purpose of the reviews are, and this is just one way to look at it. Improve individual agency actions, overall system improvements, and then of course primary prevention. I'm going to go in to this in a little more detail. Our definition of child death review what makes child death review unique is that you have to have a multidisciplinary community and you're telling the child's story.

(inaudible-garbled recording)

COMMISSIONER AYOUB: Excuse me...it's really hard to hear when there's side conversations.

COMMISSIONER COVINGTON: This is really different than what you think in public health epidemiology when you take a lot of deaths and you look at trends within those statistics. With child death review what makes it unique is you're actually telling the child's story, one child at a time. We try to understand what were the causal pathways in the child's life that got them to the death. So you're looking at vulnerabilities on their paths down that road, and you're doing it so you can figure out how to interrupt that pattern for other kids. Sort of a theoretical model. When you do it well at a state or local level you create a lot of data that gives you a pretty broad understanding on how all those different factors can interact to influence child health and safety. And then you use your information to take action to improve your agency's systems and prevent deaths. So that's kind of a theoretical underpinning.

It's got to be multidisciplinary. It should tell a story for the sharing of case information, from as many sources you put your hands on. It's focused on improving systems and the prevention of deaths, not culpability. (inaudible-garbled recording) constantly. And it's a balance between individual cases and accumulated both fatal and non-fatal deaths.

In 2014 we had child death review in 50 states. Idaho was the last comer. It's about 1,250 local and state teams. This year Guam started a team. That's where Guam is in case you don't know where Guam is. It's a little 7x35 mile island. One of the most forward moving teams in the country now. Interestingly enough. This is what happens when your legislature its only 12 Senators and the governor's wife is highly involved. The Department of Defense (DoD), we talked about this, the DoD Director requires a child death review happens when a child abuse death is suspected of an active duty soldier. So the Army is conducting reviews in all their installation levels. And then the Navy, Air Force and Marines do a command law review once a year and then they share all of that and at the annual Fatality Summit in Washington, D.C.

COMMISSIONER HORN: How do they handle a unmilitary spouse?

COMMISSIONER COVINGTON: That would be considered a case. Absolutely.

COMMISSIONER RUBIN: If it gets detected. Then Family Advocacy is probably not hearing it I do think there's a basic analysis of crossing child deaths through whether it is a national...to actually understand how they capture all of this.

COMMISSIONER HORN: It's not just that the suspected killer is a soldier.

(inaudible - several Commissioners speaking at the same time)

COMMISSIONER RUBIN: It's supposed to be both.

COMMISSIONER COVINGTON: We also have a number of local civilian teams that work well with the military and military attends their meetings. It doesn't really happen the other way because of the Military Privacy Standards Act. This is, for example, some teen members from Tacoma in the state of Washington and they had a pediatrician from the military hospital that comes and gets all the reviews. So that's kind of a typical thing

COMMISSIONER RODRIGUEZ: Is that SUID?

COMMISSIONER COVINGTON: SUID? It's Sudden Unexpected Infant Deaths. It's sort of overarching term for SIDS and related deaths. So the Navy also reviews all of those and the Army is moving that way. They found that there were just so many issues around neglect and preventable pieces on those cases that they decided to review them as well even though they are not required to.

COMMISSIONER RODRIGUEZ: So the 50-60 include those?

COMMISSIONER COVINGTON: No. The 50-60 is just their own child abuse. And then in Indian country you made the comment yesterday that they weren't doing reviews but the Navajo Nation started a team this year. We went out there and did a death review...this was a training on how to do infant death investigations. We had 80 Navajo investigators attend and then they set up a team through the Department of Social Services and actually started a review. We've been pushing them on this for a really long time because the state of Arizona was reviewing...had teams surrounding Navajo lands and when I was reading their reports 89 percent of all the deaths they reviewed were Navajo kids. But they didn't have any Navajo people on the teams and that struck me as a little bit disturbing. So we really, we presented that to Navajo and it bothered them a little bit too so they started doing reviews.

[UNIDENTIFIED MALE COMMISSIONER]: Was it just the Navajo or were there other tribes as well?

COMMISSIONER COVINGTON: No, the state of Montana, and I was actually going to suggest that to your committee can attend one of the meetings. The Crow Nation in the county, in Hardin County, Montana almost all of the deaths are Indian. Almost all of Hardin County is on Crow land. So they conduct their reviews there at the health service office with strong tribal representation. And there's two other tribes in Montana that actively are engaged with our county teams but most of their kids are Indian kids because the county's that way. This is really the only actual Indian-led child death review teaming the country.

So we have state laws that mandate for...pretty much child death reviews in 44 states. 34 of them mandate it for local teams as well. We really push the local level. Our center does anyways as most of the places that are out there. So 39 states have community teams that conduct reviews and 32 of those are doing also reviews at the state level, so they do parallel, and those state teams typically will...they are set up as advisory boards but they will often do reviews of representative cases that come from the local teams just so we understand what's going on. Then we have 12 states that have only state level teams. They do not do local reviews. They tend to be smaller states like Vermont but then we have states like Kansas and Nebraska that are really big geographically that still have state level teams..

Most teams are funded with Maternal and Child Health title-IV dollars or child protection dollars. Twenty seven states are reviewing all causes of deaths but not all deaths, deaths from all causes. And another seven are reviewing all that are not natural causes. So that's a huge improvement in terms of the way states review deaths compared to 15 years ago when they were really only looking at deaths that they thought were maltreatment. Everybody is reviewing at the age of 18 and most of the teams...it's about half and half are either based out of a public health agency or their state social services agency. Then we have a team that are splattered in other places such as the Attorney General's office.

COMMISSIONER BEVAN: Now 27 states you said causes of deaths.

COMMISSIONER COVINGTON: All causes of death.

COMMISSIONER BEVAN: Then another slide you said CDR does not focus on culpability.

COMMISSIONER COVINGTON: No, they don't. Causes of death means they review all medical causes all homicides, suicides, accidents. They are not looking to see who was at fault they're looking to see who was at fault, they are looking to see what went wrong.

COMMISSIONER BEVAN: Don't we want to know?

COMMISSIONER COVINGTON: The teams, what I mean by culpability is they're saying we really screwed up on this case.

COMMISSIONER BEVAN: We want to oversight it. (inaudible-garbled recording)

COMMISSIONER COVINGTON: These are not meant to be that they are perspective looking

COMMISSIONER BEVAN: That's why in CAPTA the citizen review panel was there to provide oversight. There is no oversight under this. -

COMMISSIONER COVINGTON: They're not set up to provide oversight. They really are set up to understand the causes and then to make recommendations about system improvements, which is oversight but it's not going at individual (inaudible-garbled recording) The teams are really very multidisciplinary. This is kind of a list of who is typically on a team and if you look at when they were first set up there was some critical they had core team members that usually focused on investigation but as they are getting more sophisticated they're starting to improve a lot more community based organizations on their teams because they're starting to really look to focus on prevention and systems improvements. So this is a very typical listing of who would be on the team. The average team in the U.S. is about 20 to 25 --

COMMISSIONER MARTIN: I would recommend that you recommend that they put a coroner in the team.

COMMISSIONER COVINGTON: I don't have it on there? They're actually on there. They should have been on the list that's just my mistake. We often have a juvenile probation officer to be there and somebody from the courts is almost always there. These are the kind of records that gets shared...the typical model in the U.S. is they don't have funding to have a case record. So people just actually show up to the meeting with their record. So you'll come to a

meeting and the medical examiner will be there with a bunch of files from his autopsies, social services will be there.

COMMISSIONER HORN: Every child death?

COMMISSIONER COVINGTON: That they review. If they do everyone. They don't do them all. They do all causes but not --

COMMISSIONER HORN: What's the distinction between all causes of deaths but not all deaths?

COMMISSIONER COVINGTON: They review deaths from any cause but they don't do all deaths. So a team might look at...they might be set up to do, they might review...well let me give you an example. You might have a state that has 10 teams and they'll review every single death but another five teams that will look at deaths for natural causes but they won't get to every single case, they have to many. So Detroit is a good example. They can't do them all their pre-natal deaths. They already have 25 a month coming just from natural causes.

COMMISSIONER HORN: So if there's like car accidents...it's in the category that they review but not every child that died in a car accident is reviewed.

COMMISSIONER COVINGTON: The smaller the community the more likely they are going to review them all but big cities cannot do them all. Big cities cannot do them all. So the teams typically...people just come with all their records. The information sharing works in most states because they legislate that people have to come and they have to share information. If agencies are asked they have to provide information. The only one that's difficult is school records under FOIA.

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER COVINGTON: So that's been probably the one area. A few years ago (inaudible-garbled recording)

(inaudible - several Commissioners speaking at the same time).

COMMISSIONER COVINGTON: Teams are typically are built on trust among members. It's just how it works. Anyone that has been on a team kind of knows that.. We kind of divide up the way that teams are focused in terms of what their outcomes should be so they're focused on improving systems, which would be improving investigation, determining how the cause of death are identified. Agencies practices and policies across a broad spectrum of agencies-- child welfare, mental health, social work whatever those agencies are. Systems who care for families. The criminal justice system and then family support. And then the prevention is...teams typically end a case looking at what the primary risk factors were in the death and then they try to make recommendations around policy programs and services that are primary ...(inaudible-garbled recording) .

Wrapping that all...most all the of the teams will tell you that if nothing else happens they start talking to each other better. We heard many times from a team member who will say we don't even like each other when we're not at a team meeting. But when we get to a team meeting, the death of a child, tends to raise, put our petty disagreements aside.

COMMISSIONER MARTIN: Teri, is there any indication that you became to receive funding and becoming more organized in their structure. Is there a reduction in the number of deaths nationwide?

COMMISSIONER COVINGTON: Deaths are definitely going down.

(inaudible - several Commissioners speaking at the same time)

COMMISSIONER COVINGTON: Child fatalities have gone down on different categories.

COMMISSIONER HORN: How many states have Child Deaths Review panels?

COMMISSIONER COVINGTON: Not due to abuse and neglect. The areas where they haven't done racial categories of suicides in the (inaudible-garbled recording) --

CHAIRMAN SANDERS: Teri, we'll have to reconvene. (inaudible-garbled recording)

COMMISSIONERS : Do we want to go have lunch?

CHAIRMAN SANDERS: Sure.

(inaudible - several Commissioners speaking at the same time)

PROCEEDING RESUMED

CHAIRMAN SANDERS: Teri?

COMMISSIONER COVINGTON: Yeah, I'm ready.

CHAIRMAN SANDERS: Okay, so we'll get started.

The first item on our agenda is our beginning deliberations on measurement and we have a subcommittee report from Teri Covington. Although I do want to point out to start this that one of our senior staff, Rachel Berger, has put together a summary of the data presented by and the recommendations made by the experts that we heard from over the last few months on the subject of counting. There were a set of questions that we had contemplated in considering this subcommittee. The purpose of counting child abuse and neglect fatalities, the short and long term strategies, what data are currently collected and long term recommendations. And these are reflective of the comments that we've heard from experts.

So we're in the...given the time limitations, we want to have as much discussion as possible. I'm not going through this (inaudible) also be available on our website so that those in the audience can see the testimony that we've heard over the last few months. I'm going to turn it over to Teri to begin to layout some of the thinking that we want to do for the Commission today and also beginnings to discussion some recommendations.

COMMISSIONER COVINGTON: Thank you, Chairman Sanders.

So what I've done is Rachel did quite a bit of work summarizing the different presentations that we've heard and then I've summarized it further into this brief slide show, just to sort of

set the stage again before I present the recommendations that we also heard and then that will open us to deliberations. So one of the first things we've learned is that the purpose of counting is to understand the scope of fatalities, so that we know how many are out there. That will help us understand then if we do them if we do interventions whether or not they work because we would have more accurate counts before and after interventions and understanding the true scope of fatalities can help us garner attention, public attention and financial support to the burdening that we've been able to truly identify.

Another piece that's important to know is that we count for different purposes. So we count to understand a population health perspective and that count is going to be larger than the count that would be conducted through child protective services, which is typically a count of children known to the system that are substantiated are verified for abuse and neglect. And then even a smaller count than that would be a count that is important to the Criminal Justice System of cases that have been prosecuted as child abuse and neglect. Most typically in the criminal division. So you can see as you think about that you have to really know why you're counting and to whom you're counting about and to what purpose you're doing your counting for.

We also know that child maltreatment deaths are counted in a number of places. Death certificates count them, but they don't count them very well because there's a few places on the death certificate where you actually list that a child died from maltreatment. In fact, there is only one external cause of death known as the Battered Child Syndrome where that can be actually listed, and so getting to child abuse fatalities to death certificates are difficult.

The state child abuse reports that are submitted to NCANDS is another source of counting. And I will get into a little more detail on that in a minute. Police records to uniform crime statistics typically counts deaths, fatal assaults that are due to child abuse and neglect. So often times you're abusive head traumas would be counted there but almost rarely would you have a neglect death counted through police statistics.

State child death review data collects data if you've had a multidisciplinary team in your state and you've entered data into a reporting form. Forty four states are using the National Child Death Review Case Reporting form to report those deaths and then the other states have their own systems. And then a number of states have their own state reporting sources often through their child welfare agencies or other sources where they're actually tabulating and keeping track of their child maltreatment deaths. So there are multiple sources.

The current national count is focused on a child welfare perspective and it's used as deaths reported through case and agency files in NCANDS. So in the 2013 report of 2012 deaths it was reported that 49 states reported a total of 1,593 fatalities. 49 states reporting 44 reported case level data on 1,315 fatalities and 41 reported aggregated data on 278 fatalities. And from that NCANDS was able to create a rate per 100,000 by the states that range from 0 to 4.64.

The interesting thing about NCANDS that we've heard from a number of presenters is that the data submitted by states is not standardized across states. So if you read the state remarks of the NCANDS report you will see that every state has a little bit different take on the data that they submit into NCANDS. A year ago a law was passed as part of the, I can't think of the title of the law. Not CAPTA, but the...I'm sorry I lost the name of the law. But it required states to

try to use multiple data sources prior to submitting their count into NCANDS so what you'll see now in the 2013 report is the number of states talk about how they try to references multiple data sources before they came up with their NCANDS report.

But I put these examples, and we're not going to go through them all, but I wanted them in the record to be able to demonstrate how different it is state-by-state when you look at the data that they submit. So, for example, Florida only submitted verified abuse and neglected deaths are counted as they say.

Georgia relies on partners in the field and they use their fatality review processes to identify a count.

Nebraska works closely with child death review but they don't include those in their counts. So you can see that there's a little bit of variety as you go state-by-state. And then state of Nebraska actually determines whether they are going to put a death in the child file or the agency file.

Iowa, they have a state child death review panel that reviews all child deaths in their state. And they report deaths to NCANDS that are a result of maltreatment. Now they don't say whether those are verified deaths are not.

Michigan doesn't report on non-CPS child fatality cases. So the only cases known to CPS get reported.

Montana said that there were no child fatalities for children in the care of child and family services in this year of reporting. However, they had two child deaths as a result of abuse and neglect. But if you look at the Montana child death review reports there's more child abuse and neglect deaths reported through their state reports.

So I only put these up as examples of the inconsistency across states in terms of how data gets reported into NCANDS. So we know that the child abuse and neglect deaths are definitely under reported and under estimated. There have been a number of published peer review articles that describe this and then the Government Accounting Office report that was released in 2012 talked about child maltreatment strengthening national data on child fatalities could aide in prevention. They basically believe that there's an undercount of perhaps, we should maybe even double the count. They pointed to some of the same issues about NCANDS that I just discussed.

I wanted to go through what a typical missed case would be. That would not make into these reporting systems. So this was a baby who was born drug exposed, sleeping on a couch with mom and dad, EMS responded and both parents were intoxicated at the scene and there was drug paraphernalia there. They had a long CPS history on both parents. The mother had lost 2 children previously in a fire when a drug deal that she'd been going on went bad and her house was fire bombed. So this case was ruled on the death certificate as natural due to SIDS. Law enforcement never got a report. CPS was not notified. And when the child death review team looked at it they called it an accidental suffocation and neglect. Just giving you a sense of where these are going.

Another, this was a baby that was born drug exposed to opiates. The mother had had 10 other children removed at various points. This baby died at two months old after being born and

going home due to medical conditions. He was underweight for his age and he'd not have any medical appointments since leaving the hospital and the mother was actively using. The death certificate said this was natural related pre-natal condition. The medical examiner was not notified because it was ruled at the hospital. Law enforcement therefore got no report and CPS never received a report.

These are not atypical cases. These are three siblings. The oldest had a history of playing with fire and had been beaten by mom for starting a small fire in the garage. Was frustrated with his fire-starting behavior. This started in a bedroom upstairs caused by a lighter with the children playing. The mother was down two houses visiting neighbors, there had been three unsubstantiated CPS referrals for abuse and neglect because the neighbors reported the mom would leave the children and go to the store. A call had come in about the mother beating Blake for playing with matches. Death certificate called this an accidental fire. Law enforcement called it accidental. They did report it to CPS. CPS called it neglect and the child death review called it accidental fire and neglect on the mother.

This is a little boy -- we see a lot of bathtub drownings -- fell over and drowned in 12 inches of water. The mother was middle income, daycare licensed provider. She went to answer the doorbell while the baby was in the tub. Talked for a few minutes with the neighbor then forgot about Darren, when she did she ran upstairs and he had drowned in the tub. The death certificate ruled this an accidental drowning. Law enforcement called it an accidental drowning. It was not reported to CPS. Child death review ruled it a drowning but they said it was neglect on part of the caregiver.

I guess I could go on, I'm going to move past these but I wanted to get you a sense of how these cases sort of fall...do you want me to go through the rest of these, Dr. Rubin?

A 13-month old child died from inflicted head trauma, beaten by her mother's boyfriend while the mother was at work. He was sentenced and convicted to prison...convicted and sent to prison. The mother had been counseled by CPS not to leave the baby with the boyfriend because of his violent history. The death was ruled a homicide. Law enforcement ruled it a homicide. CPS said they were undetermined though about the mother. And then the child death review called it neglect on the part of the mother for knowingly endangering the child with the caregiver who she knew to be violent.

This was an older boy who wandered from his trailer home and drowned in a trailer park. He had mild autism. Both parents were working outside of the house at the time. Turns out though that the neighbor had called the trailer park owner several months earlier to ask the gate to the pool be locked. He reported that he was worried the little boy next door would wonder around alone and could get into and drown into the pool. It turned out that the child death review team that they found that there were multiple calls for CPS for supervision and one of the quotes in the report was that this boy was, "this boy is going to drown one day," but no reports were accepted for investigation.

So the death certificate called this drowning, law enforcement called it drowning, CPS decided it was undetermined how they would call it and the child death review team called it a neglectful drowning.

So you get a sense about how things get coded through multiple data sources. The CDC a number of years ago funded a project to try to develop a public health more prevention-

oriented focus on maltreatment counting and what they did is they felt that if you combined multiple sources of data you would get at a better count. So they expanded the child maltreatment case definition. They expanded case finding in the collection of additional information. They looked for multiple sources of data and they did case-by-case review and they did this in three states.

In the states where they did that, Michigan, for example, this is what Michigan found in the cases that they looked at. They had zero where the manner was homicide in death certificates. Zero where the medical examiner wrote maltreatment on the death certificates. Law enforcement had no crime reports. CPS reported 22 cases of neglect, there were actually 7 criminal charges filed but the work group consensus came up with 76 deaths that they felt were due to abuse and neglect.

What they did is it really changed how they reported their data into NCANDS once they started doing comprehensive reviews. You can see where they went from zero-zero-zero to 40 and now on a regular basis they tend to report a higher number into NCANDS. They were worried at the time by having a higher report would reflect poorly on them, and that I think is a real catch-22 on our states as they think about improving surveillance that they are going to look worse than they have in the past.

You've seen this. This was presented to us but I wanted to show it again. In California they do what they call a Reconciliation Audit where they take data from multiple sources and then they fund child death review teams to do a very focused child maltreatment Reconciliation Audit on all the data sources and identify on what they would call the deaths. So they go from 21 in death certificates to 82 in homicide files, to 59 in their child welfare system to 124 when they are finished doing their Reconciliation Audit. So you can see how those numbers change when you start doing multiple data sourcing.

This is an old study that was done in Las Vegas. They had 79 deaths that they wanted looked at. Six had been coded as maltreatment from physical abuse. Nine had been substantiated as maltreatment. When the reviews were done they substantiated 37 more. And this is a very messy slide but it shows you what the types of deaths were. They are not your typical child abuse assault type cases. We have found that the states tend to be pretty well in counting physical abuse. It's when they get into looking at neglect that things sort of fall off the charts.

This, I'm not going to spend a lot of time on it but it's a vein diagram that showed...one of the things that was most interesting in the three states that were funded by the CDC is that no one data source did really well capturing any case and many of the data sources didn't capture the same cases. So you had cases, you can see how they were all over the place and it was really...even when you added them all together it was difficult to get to a true count.

The cases that were most missed I sort of hinted at this were neglect cases where there was egregious poor supervision. Where there was drug exposed or fetal alcohol syndrome infants. Where there were failure to thrive issues, failure to use generally recognized safety devices such as car seats, smoke detectors, life preservers when they should have been used. Those are really rare to get coded as neglect cases. When children are allowed to participate in developmentally inappropriate activities, when there's suffocation by overlay position asphyxiation, if the caregivers are intoxicated and when you have deaths with disabilities and impairments of caregivers that are considered neglectful when it's believed they should have

known they couldn't really take care of the child appropriately. Those are really difficult cases for people to wrestle with.

So this is a definition of neglect. Rachel put this in the report, which is that the classification of deaths due to neglect is problematic because of the lack of consistent definitions. Everybody seems to have a different norm that they use to think about what neglect is. And as you go from community to community, let alone agency to agency, you're going to find differences in those definitions. And I believe there's a lot of bias in how people describe the definition of neglect to a case based on all sorts of things including income, race, et cetera.

So one of the things that we learned about in our deliberations was that the Air Force developed and validated specific operationalized substantiate definitions. This was a computerized system that allows community decision boards to make determinations of child abuse and neglect not fatalities by the way these were just general child abuse and neglect cases. They were able to validate the definitions such that they found reliability across multiple jurisdictions when they used this system. So if a team up in Texas was doing it they had almost the same results as a team that was doing it in North Carolina using the same cases. They spent a lot of research dollars to validate their definitions. And this system is now used throughout all branches of the Department of Defense to substantiate child abuse and neglect.

Another tool that is out there and I mentioned it briefly is the National Child Death Review Case Reporting System with an extra S in the title. I will be honest this is a system that my center runs. So I have a little bias on this system. It has its strengths and it certainly has its weaknesses. This is child death review teams can enter their case data into this. Teams determine omission or co-mission on those deaths including abuse, neglect, poor supervision and we have 43 states using this system voluntarily but not consistently across all states. So, for example,, was there an act of omission or co-mission on the part of a caregiver that led to the child's death? Did they omit to do something or commit an act such as physical assault. Omission would be poor supervision?

These are the recommendations that came through our presenters. One was obviously to develop a national system of surveillance, which is based on a public health model. We heard that from almost everybody that presented on measurement that they wanted us to broaden the scope beyond a CPS focused system into a system that would be more population based. We heard from people that suggested that we develop and field test uniform definitions for maltreatment with a process for obtaining high reliability. This would be similar to the Air Force model and that we consider that model and consider also incorporating definitions that were designed by the CDC. That we should clearly determine the role of the federal and state agencies in leadership and in the funding and development of a system and how to sustain that system over time. That we should strengthen the existing network of state and local child death review or multidisciplinary teams that are reviewing these cases for the purpose of creating a national system that would give you a public health count of fatal maltreatment. And that we should determine which data systems are most cost-effective to invest in. NCANDS, the National Case Reporting systems or death certificates as critical components. Rachel tried to get some cost estimates on this and in the interest of time it was believed that we just couldn't do it, it was much too difficult to do although Dr. Slepian and Dr. Hyman submitted a letter where they tried to cost out what their Air Force model cost to do and how they could translate that into a child fatality model.

Another recommendation was incorporate uniform definitions into the Child Death Review Case Reporting System and the NCANDS system to standardize how states report deaths into NCANDS so that at least with NCANDS we would be able to count across states and that would make some sense.

Improve the identification of fatal child abuse and neglect from vital record death certificates by adding a check box to indicate child maltreatment. Rachel had broken these into short-term and long-term but I just put them all together for our conversation rather than dividing them up that way.

And then the last one addresses the whole issue of the death investigations themselves. We heard from a number of speakers including some forensic pathologists about the lack thereof, high quality death investigations across the United States. We heard from people that talked about where you had forensic pathologists and medical examiners system, they believed that the quality of death investigations is better. So some of their recommendations we heard was to develop a Nationally Standardized Child Death Investigation tool, there currently exists one for Sudden Unexpected Infant Deaths but it's not maltreatment related.

Another one was to resource medical examiners and coroners to use the tool, to contract only with forensic pathologists to perform autopsies in these cases, much like Missouri does. To defer to the forensic pathologists in determining cause and manner of child deaths, rather than leaving it to the review of coroners and others. And to transition the coroner's system to Medical Examiner systems throughout the state. As you can imagine that was in the long-term category.

That's that. A very brief summary.

COMMISSIONER RUBIN: Teri, I've got a question in terms of some of those recommendations. One of the things we heard, we have heard in a lot of places was the challenges about relying on NCANDS as being a source. Some of those recommendations are about strengthening NCANDS. Why strengthen NCANDS at all? Why not focus on what the one data system is and how the approach is going to be and not focus so much on NCANDS? Which has many other valuable services for kids but it may not be the right system from which to really strengthen -

COMMISSIONER COVINGTON: We did hear from people who said just do away with fatality reporting in NCANDS, and we heard from other people who said that NCANDS is still a really valuable source for, when states have identified a child known to child welfare system it's a very good place to put that case and it may be the best place to capture it.

CHAIRMAN SANDERS: Dr. Berger, you did quite a bit on some of the background and certainly this issue of costs and maybe have some thoughts to Dr. Rubin's question? Anything that you would like add to...you have to come up to the mike.

DR. BERGER: One of the issues about cost that we're worried about, the issues that none of these systems only count. So you can't look at the cost of counting in and of itself. You have to look at the cost of the system to collect, data about risk factors, for example, and counting and all these other things that the systems do. So you can't say it costs us this much to count in NCANDS, you can only say this is how much the system cost us to use as a much greater system. Similarly, we were a little bit nervous about the issue of NCANDS. Like

NCANDS has tons of strengthens and data elements related to risk factors. Related to counting it may not be the best system but when looking at an overall recommendation it's hard to say, I want to do all this for counting, and then I want to use four total different data systems for risk factors, because in the end you need single coherent plan of a data collection system.

So we were a little bit worried about just kind of trying to pull out counting. I pulled out all the data elements just related to counting and we'll do the same thing on risk factors and some of the ones...death certificates don't give you anything about risk factors but they do potentially provide a count. They each have different strengths and weaknesses.

COMMISSIONER RUBIN: So I guess what we're describing in this new world sort of how these different systems...are the states using NCANDS as a way to make sure they identify...if one of those systems their identifying more cases from...like how would this create in some ways some of those standardizations of workload by which states really try, as best as possible, to identify kids?

DR. BERGER: I think some states use NCANDS really diligently and deliberately to do that but I don't think...they obviously all do that. You should probably go through it and figure it out --

COMMISSIONER RUBIN: Should they be using NCANDS as one of their sources? Should we...is that what you're saying by the strengthening recommendations?

DR. BERGER: Are we to the point where we can truly discuss opinions now?

CHAIRMAN SANDERS: I would actually suggest that if you have some specific thoughts we have a lot of recommendations out here based on what you reviewed. I think particularly -

COMMISSIONER RUBIN: I need some guidance from someone who's worked with this throughout her entire career.

COMMISSIONER COVINGTON: I don't think we should throw out NCANDS for child fatalities. I think we should...I would love to provide guidance to states on NCANDS about how to report fatalities. To say either we want you to report fatalities that you verified or...because I know, for example in Michigan they report cases of any kid that they know who died that was known to the system. Whether they end up verifying the case or not. That's one example. Where another state will only submit data on the kids that they knew about, that they verified, that were known to the system. So you could create a standard for NCANDS and for me it wouldn't just be cases that were verified in kids that have been known to the system.

I would say any child that child welfare knows about that they end up verifying, for example, due to child abuse and neglect. To me, that's good enough. That would be a huge improvement over the one we have right now. But I get worried about some states only reporting kids that had prior history with the system and those are the only ones that they report, versus all the kids that they end up substantiated or verified. There's a big difference there with those kinds of kids. I worry because when states only do kids that were known to the system, to me, understanding why kids who died weren't known to the system is just as important as understanding what was going on with kids that were known to the system.

CHAIRMAN SANDERS: Commissioner Rodriguez.

COMMISSIONER RODRIGUEZ: Is this set of recommendations the right place to tackle that piece from our subcommittee around making recommendations, around amending the definition of children known to the system so that NCANDS has a more accurate count?

COMMISSIONER COVINGTON: I think it's open to us. I think we should be more prescriptive on what we want that definition to look at.

COMMISSIONER RODRIGUEZ: To me, it logically fits with this piece if we're talking about count and sort of giving some guidance to states on how you count and setting uniform definitions. It seems to me like making sure that the definition of a child known to the system gets accurately captured so that we get a better number than that 30 to 50 percent.

COMMISSIONER COVINGTON: I personally am a really big fan of the Slepian-Hyman work. I've seen it in practice. It's impressive. It really blows me away. They are actually implementing it right now in Alaska. It's the first state that's trying to replicate it. They have a highly skilled child maltreatment epidemiologist that's working with the state of Alaska. They have a team that they've set up so they're looking at every death and running every death that comes through the Medical Examiner's office through that algorithm and it takes away a lot of the...A, it takes away a lot of the bias. Even though everybody kind of makes decisions all the way through. The validity that they were able to get regardless of who did it or which jurisdiction did it says to me that what they're ending up with is a really pretty true count. So I'm a big believer in figuring out how to adapt that model into states. Where you adapt it is the question. To me you've got these child fatality panels, we talked about it earlier. Whether you're talking about the broader based panels or the MDTs that are just looking at maltreatment, where you put that is a question. But I'm a real believer that we ought to create a model that would give an almost objective way to count maltreatment cases that would be used as an easy decision making algorithm much like they're using in the military. You'd run all those cases through there, you come up with an answer. That's what gets entered into NCANDS and that would be to me what you'd also enter into the National Child Death Review Case Reporting system.

We had some meetings where we talked about even changing the Child Death Review Case Reporting System so you build that algorithm right into the Case Reporting system. So you would be sitting there online entering the answers to the questions and it would actually spew out the answer rather than the teams having this very difficult decision about are we calling this neglect or aren't we calling neglect. Where is the bar? Because that's what teams get into and that bar changes depending on where you live and who you are.

CHAIRMAN SANDERS: Commissioner Martin.

COMMISSIONER MARTIN: So I have two questions. One question directly related to this but I have a general question about what we're doing in this deliberation, if you don't mind. I'm sorry. Are we doing this right now and talking about the summary of this data so that we can come up with a potential interim recommendation regarding counting or are we doing this to kind of work toward or put work into one subcommittee?

CHAIRMAN SANDERS: Maybe not understanding the second part of that. So the...one of the reasons we had sequenced counting so early in the process was because it's critical for our determination of future recommendations.

COMMISSIONER MARTIN: Okay

CHAIRMAN SANDERS: That we have...Congress has been clear that NCANDS is an undercount. If that's the case then how do we rectify that given our charge of eliminating child abuse or neglect fatalities. So Commissioner Covington's work in the subcommittee is really intended to give us the lay of the land so that we can have some deliberation about what that new count should be. Or at least what the mechanism to come to a new count should be.

COMMISSIONER MARTIN: Okay. So then my question to Teri, the model that you were just speaking about, the DoD model...and I understand that the Department of Defense is large but is that something that you think can be applied to a larger state somewhere other than like a rural state like Alaska?

COMMISSIONER COVINGTON: I think it has to be tweaked a little bit because it wasn't developed to be a fatality specific and we talked with Dr. Hyman and Dr. Slepian and they both had said that it was something that they felt could be done was you would have to tweak the questions a little bit with the focus on fatalities.

COMMISSIONER MARTIN: And it would still maintain its validity?

COMMISSIONER COVINGTON: They would have to test it. I don't think it's something you just drop in tomorrow. It would have to have some research behind it. To sort of field test it and test validity of the question. You would have to run it through a number of jurisdictions to see how it worked?

CHAIRMAN SANDERS: Commissioner Bevan then Commissioner Petit.

COMMISSIONER BEVAN: Okay. I'm back to where I was in the beginning on the purpose of counting, 'cause I think we have different purposes.

My purpose of counting is to find some culpability if we're going to eliminate child abuse and neglect fatalities we are going to have to punish the perpetrators. We are going to have to provide some awareness about this issue and then go ahead and fulfill the law enforcement folks. If we do it in an aggregate way and try to do system improvement, that's not going to eliminate child abuse and neglect fatalities. In the way I think.

Second is if we are not, the purpose of counting also would be to take a look at these teams and hold systems accountable and provide oversight. There is no oversight right now for child welfare law enforcement and all these people that sit in a room and talk about child fatalities. There is no oversight over what they have done or failed to do in terms of a specific child death. So I'm confused about the purpose of counting.

COMMISSIONER COVINGTON: I can tell you that in terms of your issue about getting justice for children, when these reviews happen and you have, you always have the prosecutor at the table. You have law enforcement...I can't tell you how many times they go back and they start filing charges. Those examples I gave you that's one way that they actually identify.

COMMISSIONER BEVAN: But I don't want to leave this to chance. I don't want to leave it to someone who perhaps happens to pick it up. I want it required. My other question is...you handed out the...in terms of NCANDS in one part of what you said, you said that NCANDS,

again under CAPTA, NCANDS is required. CAPTA is required to establish national data collections and then that data collection system is NCANDS.

COMMISSIONER COVINGTON: It's still voluntary submission by the states.

COMMISSIONER BEVAN: So then, we have to do something about when we look at CAPTA we have to look at how can you require the establishment of a National Data system an analysis system and yet allow states to voluntarily submit the data? No that doesn't make sense. Also, clearly we've learned here that the citizen review panels the way it's structured, it's been in there since 1996, the difference to for secure review panels, I mean, they don't even exist. They don't exist either. The language on fatality reviews wasn't real meant to establish national fatality review committees. It was just said that, "if this kind of entity exist that we didn't want to create another entity on top of that." So all of that language now has to be reviewed and figure out what is correct. Because it doesn't make sense to keep the language the way it is. I still have a concern of why we're counting.

CHAIRMAN SANDERS: Commissioner Petit.

COMMISSIONER PETIT: Teri or anyone here, staff or other commissioner members, GAO issued a report, they found many of the problems, they confirmed many of the problems that all of us in one way or another were saying before their report. They issued recommendations. What is the status of those recommendations? Has the HHS picked up on them? Who at the federal government is at this point --

COMMISSIONER COVINGTON: The major change at HHS picked up on, I believe is the requirement now that the states have to identify the multiple data sources that they consort when they submit their count into NCANDS.

COMMISSIONER PETIT: But how many recommendations were made by GAO?

COMMISSIONER COVINGTON: Oh, gosh.

COMMISSIONER PETIT: One of the things I think we ought to get before we address this issue finally is get an inventory of exactly what those recommendations were and what actions, if anything, has been taken on them. That would tell us something. It would tell us either they love them and they're implementing them and they think it's going to help things or they don't think that they're helpful and they don't want to do it and so nothing is happening. So I'd like to see what that...I would imagine at some point the committee of Congress that directed that the GAO study be done would also be interested in exactly what came out of that report. That was Camp's committee, I think but he's gone so whoever it is that there's now.

COMMISSIONER BEVAN: He's not gone yet.

COMMISSIONER PETIT: Right, right, right, he's not gone yet. That's right. (laughing)

COMMISSIONER COVINGTON: That's a good point.

COMMISSIONER PETIT: I don't know David who would that but --

COMMISSIONER BEVAN: We can wait until there is a budget.

CHAIRMAN SANDERS: I think that can clearly be one of the questions that we put to HHS. Commissioner Horn.

COMMISSIONER HORN: First of all, I want to say that I'm very impressed with the set of recommendations. I think they are very much reflective of the testimony that we've heard. They seem to be extremely well thought out and they have a nice consistent theme. I think that what I would encourage us to do is to take it to the next step, 'cause it's a little bit unclear to me which of these recommendations are recommendations for federal legislation, which of these are recommendations for states to consider in terms of policy making, and who would do some of the sort of development work that you request.

So developing a National Standardized Child Death Investigation tool, is that something we as a Commission would recommend the Children's Bureau to fund or would it be done someplace else? So I think this is a terrific launching pad and what I would hope is that we could develop some more specificity and take it to the next level.

CHAIRMAN SANDERS: Commissioner Rubin.

COMMISSIONER RUBIN: Because this was developed before this meeting, to answer Cassie's question, we count because of something we've been discussing. We have no mechanism right now to measure outcome. Whether our efforts, whatever we are going to come up with in terms of recommendations to actually reduce serious injuries and fatalities. I put serious injury in there because I think we heard very persuasive testimony yesterday that we should be coming up with a mechanism to count both the fatalities and the non-fatal serious injuries, 'cause they come from the same group...they are principally the same kids. Only when you can do that reliably and with some level of validity can you then start to look at the impact of our interventions whether they are integrated functions, there are law enforcement functions, right now I have no idea. I tend to think they are going up because the non-fatal injuries are going up across children hospitals on average, although there have been some variations year to year, but we need to be able to rely on every measure of what's going on so we can have some impact.

COMMISSIONER RODRIGUEZ: I think I agree with you about the impact. I think the culpability is important but that the goal moving forward has to also be for children who we have a chance of intervening with that we're able to do that effectively. To me, that's sort of the reason that you would convene people and use resources and energy is to think about all the children that you could do things differently for.

But I also wanted to make sure that...I don't see that the issue got captured around making sure that we revisit the definition of children that were known to the child welfare system so that we get a more accurate count.

And then the other group I think of children that I'd like to propose that we begin counting is children that we could classify as a fatality due to "system neglect" and this would be children for example who commit suicide while in foster care or in the Juvenile Justice system. Young people who as discussed before are trafficked while under the custody of the child welfare system. I mean, under the type of system that you described I can't imagine sort of a group of people looking at some of these cases and not saying there wasn't neglect on

behalf of...there was no parent necessarily involved in that system but there was a custodial caretaker and that was often the system.

COMMISSIONER COVINGTON: The child death review system gets to that 'cause they have a whole section that addresses deaths of kids in institutionalized care.

COMMISSIONER RODRIGUEZ: Perfect.

COMMISSIONER COVINGTON: So you can poll those cases.

COMMISSIONER RODRIGUEZ: I think our system should be capturing them and flagging those because I think those are some of the cases that we can learn the most from. And they are going to look really different I think from the typical death of young kids.

COMMISSIONER COVINGTON: It's interesting that when we pull up data on child maltreatment from our system we do find a number of suicides where neglect is listed as a underlying cause of death in those suicides, which is an interesting sad outcome.

CHAIRMAN SANDERS: Commissioner Martin, then Commissioner Horn.

COMMISSIONER MARTIN: I think Cassie's question is very important, what is the purpose for us to really focus in on the counting. Cassie I haven't thought this out entirely but off the top of my head, culpability doesn't necessarily lead to better accountability. So for instance if you think about some of the things that we look to in the crimes that we prosecute in our society that doesn't necessarily prevent or deter those crimes from occurring again. We talked about originally giving the death penalty to deter murder, right, and that doesn't deter. I don't think just focusing on culpability necessarily is the answer to reducing or eliminating the fatalities in the future. More importantly I think there are better ways to address and better methods in which to go after the person, find the person who is guilty or find the person who has committed or find the preparatory and then reinforce the system where it sits to prosecute that person. I think there are other ways --

COMMISSIONER BEVAN: You know that better than I do. I just do want to do the finding.

COMMISSIONER MARTIN: I'm not saying we shouldn't. I'm just saying --

COMMISSIONER BEVAN: They are not happening.

COMMISSIONER MARTIN: But I'm just saying that this is probably counting and making certain that we really have a clear understanding of what our abuse and neglect numbers look like is probably not the best way to get at the perpetrator, is all I'm saying. I think there are other ways in which we can do that better and so I would not ask this committee to necessarily look at the purpose of working on counting for culpability purposes. That's all I'm trying to say.

COMMISSIONER BEVAN: Do you look at it through the courts? Do we put it through the courts?

COMMISSIONER MARTIN: I think there are other ways to do it. I think there are a number of ways.

COMMISSIONER BEVAN: Do you want to articulate those other ways?

COMMISSIONER COVINGTON: I think if you improve the quality of death investigations you're going to improve identification of where harm occurred because you're going to start doing these cases better and you're going to find...if you're doing good investigations you've got law enforcement, prosecutors, and everybody at the table. You're going to do a better job.

COMMISSIONER MARTIN: I think we've heard a number of ways even through the testimony we've heard. So we've talked about Child Advocacy Centers and that's one place that they have the prosecutor there from the beginning of the investigation so we can look at strengthening those kinds of programs that I think would far out-see our abilities to get a culpability from this angle. Is all I'm trying to say.

COMMISSIONER RUBIN: Plus the near fatal reviews are actually in real time in the prosecutor's office is there. Standardizing a near fatality review actually gets at the issue you're raising, big time for those kids.

COMMISSIONER COVINGTON: The thought about the Child Advocacy Centers may be important to put under the quality of death investigations because we could add that...we tried to use them more aggressively or more often for cases of all types of abuse not just sexual abuse.

COMMISSIONER MARTIN: Expand the purpose.

COMMISSIONER COVINGTON: Yes, expand the purpose.

CHAIRMAN SANDERS: Commissioner Horn.

COMMISSIONER HORN: I don't think that the issue is about accurate counting and justice for children who have been killed are mutually exclusive.

So as a first step it does seem to me that we have to have accurate counts and this sort of recommendation goes a long way toward that. I was so busy complimenting you on your work I forgot my second point, which was that we heard testimony yesterday that something I did not know, that Native Americans are not included in NCANDS. And while the number may be small, we don't know what the number is and if it makes sense to be accurate in our count for non-Native Americans we should be accurate in our count for Native Americans as well. So I would suggest that we put on the table a recommendation to implement actually the study that was done by the Children's Bureau to include Native Americans in NCANDS, including the reporting of fatalities.

Then I just want to, I'm very, very impressed with the really good work that shows there's almost no difference between deaths and near deaths, except that one you have a dead child and one you have that is still alive.

But in terms of all of the other contextual variables, they look almost identical, which is really quite...it's almost like if I made up the data I wouldn't make it look this consistent. So I think since we just heard about that yesterday, I think one of the things that we should do is explore what it means to include near death data also. I'm not sure it will be as easy in some ways to include that as to get a more accurate count on actual deaths. But it's certainly worth exploring and I certainly would be in favor of this Commission in taking a look at that.

CHAIRMAN SANDERS: Commissioner Ayoub.

COMMISSIONER AYOUB: The number one recommendation is to develop the system based on a public health model. Does everybody have the same definition of public health model?

CHAIRMAN SANDERS: Actually, that was a question that I had in the public health surveillance.

COMMISSIONER RUBIN: Well, I think there is...the problem that I have seen and it was raised by a lot of our speakers is that...is the subjectivity involved with the assignment of the child abuse label. And particularly when the reporting source is going up to a specific data system, like NCANDS, which is around child abuse reporting, what it does is inherently there's a problem with reliability or validity in the study. So the public health approach says that the denominator really here is all deaths. And when you look at sort of the work that Dr. Slepian was doing that Commissioner Covington referred to, what their saying is, can we come up with an objective from a public health perspective that includes everyone's opinion at the table and a standardized decision making tool. We may still have some error around the edges but everyone is going to be on the same playing field and using the same kind of calculus in terms of doing counts. So, therefore, you now have created a better ability from a public health surveillance perspective to know when I see a bump in my rates that I need to go and investigate why that's happening. To compare community one to community two, et cetera. So the public health model permits that.

Now, I don't know if that totally answers because it's sort of your asking to define an abstract concept 'cause it's like saying that child welfare is not child protective services; it's the entire community response and intervention.

CHAIRMAN SANDERS: Commissioner Petit. Then Commissioner Martin.

COMMISSIONER PETIT: I'd have to see specifically what the public health surveillance model looks like in a practical application to be able to say it could serve as a substitute for CPS investigating. When CPS and these panels review a death they go into a very facet of a specific individual case. The public health thing does it actually look at each case.

COMMISSIONER RUBIN: Oh, no, CPS is still driving it. I mean, they are at table. Like, what you've done is you removed the conflict of interest in terms of data reporting source. CPS it doesn't change the dynamics of CPS as a central role in the substantiation process and the participation and the review teams.

COMMISSIONER PETIT: Okay. The second point is where it says "It improves the quality of death investigations," I'm still looking for improves the quality of intervention investigations. In other words you have DA's that after the fact with a dead kid says, "You know, we should have sought and then ensured that a protective order ordering the perpetrator stay away from the family was implemented."

Well, there's numerous models where that is incorporated' where there are MOUs that specify what constitutes in effect good practice. So we're exactly right to be on this post-mortem but I keep returning to the pre-mortem in terms of stopping the deaths of several thousand

children who we know right now are involved with the child welfare system are not going to make it through this year or next year.

COMMISSIONER RUBIN: Well, that's where those near death reviews -- I mean, if you heard the doctor, what did she mention 140 actual recommendations that have come out of that review team so far in Philadelphia out of that Act 33 review. I think that's kind of the responsiveness you're looking for. That Public Health model says, "Everyone around the table were reviewing in real time these near fatalities so these kids are still alive and their siblings certainly are at risk." So I think when it's working well and you have everyone at the table you can actually have an impact across systems.

COMMISSIONER PETIT: I'm talking about the week before the kid died the group is given an assignment to protect that child because certain factors have entered the picture which now looks like the kid is more at risk than before. So now that doesn't happen, the death occurs, and then we say, "Well we should have done this, we should have done that."

One of the things I guess is that CAC model, the Child Advocacy Center model, which I think is a very good one, it just happens to be confined to sexual abuse cases for the most part, so I guess one of the questions we're going to raise is, is that a proper vehicle, which you had raised, Commissioner Martin, I think that's where I'm going with this thing, knowing how the deaths occur is critical, stopping the deaths in the first place. What can we draw from what we've learned to apply going forward?

CHAIRMAN SANDERS: Commissioner Petit, not that they're mutually exclusive 'cause I think that's absolutely the case. I think that the focus here was purely on the counting piece and not on how to make the improvements as a result of the counting. And I think that you're right that that needs to be considered and we should consider it, should it be part of these recommendations or this set of recommendations or should it be part of something?

COMMISSIONER PETIT: I think that's a very good point. What I would urge happen is that we actually bring some people in who practice that model right now ahead of time. There are some local places where that actually is occurring right now. There are MOUs between the DA, the police, the emergency room, et cetera, and we've heard some groups touch upon it over the last four or five of these events but I think just as we're devoting time, subcommittee, et cetera, to this now, that's something...I'm not saying to do it tomorrow but as we move forward on this it would be interesting for all of us to hear, "so how are you guys making this work." So it is resulting in fewer kids being killed because the death rate isn't the same in every state or in every jurisdiction within a state.

CHAIRMAN SANDERS: Commissioner Martin.

COMMISSIONER MARTIN: So the way I try to define the public health approach or model to me is when it comes to the actual counting of the child abuse and neglect deaths, I look at it as a more inclusive count. So it's not only the agencies count but it's also the doctors count, the hospital count and somehow, I don't know how, but somehow making certain that there's a combination so we gather all those kids as oppose to just the kids that are known to CPS.

So what I'm trying to say is, I don't disagree with Commissioner Rubin's statement, but I really do think that what we're all saying is a more inclusive count so we get the kids that are at the attention of CPS as well as the kids who are not at the attention of CPS. But I also think that

involves a conversation of who counts. I mean, we had some testimony throughout these last four or five months that talk about whether or not it should be left to the responsibility of the agency to report the final number to NCANDS or whoever it's reported to. And we talked about medical examiner offices and how those are done and the structures of some of those. And so I think this discussion also includes who does the counting as well as the actual number and how it's counted.

CHAIRMAN SANDERS: Commissioner Rubin, your description, what I had understood from this conversation from the presentation was that part of the public health surveillance means the who counts is not child protection; that it falls...

COMMISSIONER RUBIN: Transparency is the word. That there's a confidence at a community level that every kid's story is told. So by having everyone around the table it removes sometimes justified but most often not the potential concern that an agency is not uncovering all the cases. So it is a higher level of public confidence that every case is counted and reviewed.

CHAIRMAN SANDERS: So Commission Covington had to leave to catch her plane and I know Sheryl Blanch has been capturing much of what we said. There are a couple of things I wanted to touch on because it seems that these are directions that we want to go following this meeting then I'm going to ask Dr. Berger if she has anything to add.

One is the GAO recommendations and getting an inventory and one of their recommendations was to consider using multiple data sources versus one data source and it seems that we should have some idea of where that is, 'cause if there's been any movement on that then perhaps that begins to say that a public health surveillance system is the direction in which things are moving.

A second is to analyze the recommendations for responsibility, state and federal, which agency at the federal level, is it regulatory, statutory, but really to kind of take a look and I think that was your recommendation Dr. Horn to look at the set of recommendations. The revisiting of the purpose and what I heard Dr. Bevan was oversight and accountability. Not that those are pieces that are critical for the purpose not just the culpability although that's a piece but also oversight and accountability. Is that accurate? Because it seems that we should look at trying to revisit the purpose.

And then there were some specific ones the revisit the definition of children known to the system. Consider the definition of system neglect, recommend the count for American Indian children and consider the new death data.

These are all pieces that we want to look at for the subcommittee, and we'll capture additional details, but does this seem the direction between now and the next discussion that would provide some additional information that would be helpful in this area?

COMMISSIONER COVINGTON: That's a good summary of what we just discussed.

COMMISSIONER RUBIN: The only other thing I would add about the public health model, remembering the counting is really, is the surveillance, it's the measurement. In the public health model you can only manage what you can measure, 'cause otherwise you don't know whether your interventions are making a difference. So as you roll up that public health

model what are the interventions both for kids who are known or not known to the child welfare system. These are the kind of discussions we've had about moving some of the interventions upstream, some to be responsive to very proximal causes of death for kids who are known and everyone is worried about, but it's part of that global approach and until we know what we're measuring, we're not going to know whether we're achieving any level of impact.

COMMISSIONER BEVAN: I'd like to include Commissioner Martin's point that she said that there are other ways of getting at culpability. I don't know what they are so I would hope that somebody would look at them for me.

COMMISSIONER MARTIN: But I think one of the suggestions we've heard while sitting on this Commission about the review of the near fatalities, and so that is a real good place to start looking at whether or not we can strengthen the systems for accountability. It seems to me that when we're discussing a perpetrator that provided a child with scrambled eggs for a brain that we can start talking about whether or not that's the time to prosecute or whether or not we need to have an order of protection that if he violates again. So that's a good place to find out who's responsible for that severe injury and prosecute from there. I mean, that's just one example, I think.

COMMISSIONER BEVAN: And if the multidisciplinary teams, the CACs, will include looking at that, my concern was that that was being excluded.

(inaudible - several Commissioners speaking at the same time)

COMMISSIONER PETIT: That model needs to be looked at closely and we haven't looked at it, the CAC thing. I know from some that I've dealt with it doesn't include those elements.

David, I wanted to address your summary that you made on this thing. This is in the context of what the full magnitude of our responsibilities are. I hoping that there's a point at which we take this counting issue so far and say, this is our best thinking and our recommendation on it. But I don't believe that our little panel needs to define exactly what that process is going to be. I mean, there are allegiance of people in the federal government and academia who, this is what they do.

So to the extent that we say we confirm GAO, we think here's another way to do it, here it is. I'm thinking of the other stuff that we need to get on to on this thing. So at what point do we say we draw closure on this and we move on to something else?

CHAIRMAN SANDERS: I would suggest, then, I think Dr. Horn's recommendation around analyzing the responsibility would be a piece of that, so that we can break the recommendation out into responsibility and decide if we're in agreement with the set of recommendations and then move on. Because we'd have to know who to ask in federal or state government or who to make the recommendation too. But once we have that, then we will have an opportunity to vote on it.

COMMISSIONER PETIT: Because the counting thing as important as it is on the short term, it's not going to stop child abuse fatalities. It's critical, it's important, I buy it, it's good, we need to do it but in terms of what are saying right now that we feel we need to do starting tomorrow. We wish you to report in what you're saying if you did this, it's a likelihood that

you will shrink the number of deaths in the immediate future. What are our goals? There are such things.

COMMISSIONER HORN: I don't think anybody disagrees with your saying. It's the impasse. I think, right now for this discussion we're talking about counting. That does not mean that we don't care about the other stuff as well.

David, let me ask you: So you mentioned something that I didn't hear in the initial presentation about multiple data sources. What do you mean by that?

CHAIRMAN SANDERS: Well, actually a couple of things. I think in the presentation I was struck by the slides that I included, I believe it was Michigan and California that looked at using the child protection-only data source and then added additional data sources and the numbers of fatalities due to abuse and neglect were higher than the ones just using the child protection data source. That was one.

The second was in the GAO report the recommendation to continue consider using multiple data sources versus a single data source. That's what I was referring to.

COMMISSIONER HORN: Okay. So you're talking about using multiple data sources into a single process that ultimately makes the determination that sends the count up.

CHAIRMAN SANDERS: Yes

COMMISSIONER HORN: I thought maybe you were suggesting that multiple data sources be reported and somehow somebody magically puts them together.

COMMISSIONER RUBIN: One thing that wasn't...I'm not sure, and I'm still chewing on what Commissioner Bevan talked about, the near fatality reviews, which I encourage you to come to one of. The Act 33 reviews, are great because they are very proximal to when the injury occurred. The fatality reviews are happening many...like a year later, right, Dr. Berger? And we did have testimony that there isn't the same wheels of urgency and yet there are siblings at risk.

And so I am wondering, and I know Commissioner Covington left, what are the recommendations going to be about expediting information sharing and availability of information to conduct those reviews. And I think that is a space we might want to get to because it's not just culpability, it's about child protection for siblings and other kids who might be at risk.

COMMISSIONER BEVAN: Being able to use the current law. I mean, if you have aggravated circumstances and some of those...a lot of the cases that she brought up -- I mean, the mother had already had TPR and there were 10 kids. Why are we not using the bypass of reasonable efforts?. Why?

COMMISSIONER MARTIN: If I might, those are laws that are on the books.

COMMISSIONER BEVAN: Right.

COMMISSIONER MARTIN: And so it seems to me that that is separate and apart from our charge here other than encouraging prosecutor offices to proceed to TPR by motion so we don't have to re-notice.

COMMISSIONER BEVAN: But it's a federal law and it's not effective if it's not being implemented. Right?

COMMISSIONER MARTIN: Okay. Then maybe I'm misunderstanding you because I think actually that those laws on the books are pretty good and it's just a matter of the prosecutors electing to utilize those. And so what I suggest is that it doesn't...we're not precluded from suggesting for the SIDS, in these particular cases. I mean, just one example. When there's a death of one child and there's siblings at home to suggest that the prosecutors really examine the laws that are currently on the books to expedite TPR or expedite anticipatory neglect and all those other great laws that we have on state laws as well as federal laws on the books currently, which they currently bypassed.

COMMISSIONER HORN: It seems to me, Cassie, you are getting into two issues and I just want to be clear about them. One is to establish who is at fault to get justice for the child who is dead. The other is to use the process of a way of improving things for other kids who aren't dead yet.

COMMISSIONER BEVAN: Right

COMMISSIONER HORN: And I think that's where you're going, which it's not just counting for counting sake. So we come up with a number that we have a .99 percent comp level instead of .88, big deal. That's not the point. The point is to establish justice, which I totally agree with you, but also to make sure that that information is being fed back into the system so that future kids are not at risk or least reducing the risk that those other kids will get killed. I'm not convinced that the process right now does the second really well. I think that's what you're saying. We've had these child death reviews in place for a long time, why do we still have so many problems.

So I think we have to be much more focused on how we use the results of those reviews. Not just to get an accurate count but to improve the system.

COMMISSIONER RODRIGUEZ: But if that was your goal, if your goal was actually to be able to take action on siblings who are still alive in the case then you would have to restructure this process so it had some urgency to it. You can't have that review happening 12 months after the fact, they would need to be on a very fast timeline. Not even the 30 days that you talk about with the near fatality review but quicker than that. If you think that other kids are still at risk.

COMMISSIONER PETIT: CPS per se, as soon as that happens should be on it within minutes or hours after this has occurred.

COMMISSIONER RODRIGUEZ: I think that's what Judge Martin is saying, is that the existing system is set up so that if there is something else that needs to happen in terms of reflagging the system any time a child who has any sort of child welfare -- who has siblings basically or other children in the home die, that there's some immediate urgent sort of case brought to

the court, brought to child welfare that's outside of this child death review. It doesn't seem like you'd want to wait at all ever.

CHAIRMAN SANDERS: Let me just make two points and we'll see whether we want to continue with this discussion or move to our final agenda item.

The subcommittee was brought (inaudible) recommendations really focused on how to improve the count. And clearly these things are tied together. But it seems that that was the first step. I would note as my second point that child death review is not necessarily referred to specifically as one of the things that is a must in improving the count. It's identified as one possible mechanism but there are other mechanisms and so I don't think that there's anything here that locks in child death review as a process to improve counting. So the issues around definition are part of that. So I'm not sure that the child death review team is something that we need to continue to talk about but we certainly can and I think particularly in the context to what Commissioner Petit raised because it is how do we ultimately prevent and eliminate the fatalities. And I think the processes we have in place aren't going to accomplish that. But this is really specific to counting.

COMMISSIONER RUBIN: There's an overlap because in my field, if we had a central line infection of a child who had intravenous and dwelling line who was ill in the hospital and that child died from a central line infection. We wouldn't be waiting a year to review that case and making recommendations. It would initiate an immediate root-cause analysis. And so somewhere in between there is performance improvement.

CHAIRMAN SANDERS: We could at a later point say we don't have confidence in child death review. That wouldn't necessarily impact your recommendations out of the county, yet. I mean, we would have to --

COMMISSIONER RUBIN: I think they just overlap. They both count but they also have this performance improvement and immediate need to protect children who may still be in the home.

CHAIRMAN SANDERS: But we could chose, for example, to recommend multiple data sources that include the child protection report --

COMMISSIONER RUBIN: Sure

CHAIRMAN SANDERS: --the law enforcement data, or FBI data and death certificates and not have the count piece related to child death review. That's all I'm suggesting.

COMMISSIONER RUBIN: Oh, absolutely. And one of the things I did disagree with earlier on, which is, I think, Commissioner Petit, you said we shouldn't be making recommendations with all the folks who are smart out there. I feel like the field needs some level of standardization of an approach as recommended by the Commission. There are enough people who have thought about this but I think that we can't continue to operate in a sort of...everyone has their own method.

COMMISSIONER PETIT: I feel misquoted on that. (laughing) I'm not sure what the quote was but let me just (laughing) --

COMMISSIONER RUBIN: All right. Maybe I misquoted you, go ahead.

COMMISSIONER PETIT: If you all recall what we heard today is that the number of staff that are involved with this stuff ranges from a low of two or three to a high of as many as 15. So if you take a look at the total amount that is being spent on this it's a very modest sum of money. The amount of money that would be needed to upgrade it in terms of the capacity would be a very modest sum of money, a few million dollars. I'm not saying that's what we should do but part of the reason for the delay is they just have other stuff that they're working on relative to this, they are triaging, I don't think the one year was an average for you and Jennifer, just my experience with child welfare on that sibling issue, and the Judge might be able to talk about this thing, there are very few circumstance where if a child was ever killed in a household or severely injured that they would leave siblings in that household. The court would call upon the department.

COMMISSIONER RUBIN: But it's not those kids. It's the kids who are "not known to child welfare whose death reviews wait a year" and they linger and linger and linger. So those kids I feel comfortable. A child who was on a child protective services caseload who died and they knew about will initiate that response. It's the kid that a year later we say, "Oh, by the way, this kid is also a child abuse death." That's the kid I worry about and the kids siblings and all the misses along the way.

COMMISSIONER PETIT: Again, it's not just the process but it's also the cost of the process. So is there a capacity to do it, and we haven't addressed that question yet. Although, Teri certainly has voiced concern about that over the years.

CHAIRMAN SANDERS: Dr. Berger, is there anything that you'd add?

DR. BERGER: About the public health? I think the term that we often use in public health is the preventable death, which is a much bigger umbrella. So you could have a preventable death, for example, that's due to a product safety problem, and that was actually one of the things that child death review started to do, is to say, these children die in some kind of seat and it turns out there's a problem with the seat. That's a preventable death but we wouldn't include it under...it would be in a public health model 'cause it was preventable but it would not be included in child abuse and neglect. So I think that public surveillance gets to all preventable deaths, recognizing some drowning might be tragedies in the true sense of the word. Like, they had a gate and the gate malfunctioned but everything else was correct. There's an adult having a seizure and that's why they weren't watching the child or something like that. It's preventable but it was not abuse.

So that's I think how we look at that from a public health perspective, that much larger view.

COMMISSIONER RUBIN: I think that's a good way to classify it.

Dr. Berger: I also did a summary of the GAO recommendations, which we handed out a while ago, but we can just resend those. So we actually enumerated all recommendations.

CHAIRMAN SANDERS: And do you have the status of the recommendations?

Dr. Berger: We don't have the status but we can add it because we already have a list.

COMMISSIONER AYOUB: I didn't see everything that was on this presentation in our package. I saw your recommendations. It's what she put out about the different states and certainly the cases that she gave us as examples, that would be very helpful to me. Do we have that? Am I just not seeing it?

COMMISSIONER MARTIN: No, we don't have that.

COMMISSIONER AYOUB: Can we get that?

CHAIRMAN SANDERS: Anything else, then, on this?

So we'll go back with the subcommittee with some next steps to take and then be brought back to the full Commission.

COMMISSIONER HORN: I think we are in violent agreement.

(laughing)

CHAIRMAN SANDERS: So our last agenda item is on confidentiality and we have a document that can be passed out that Hope Cooper and Marcie Roth -- Marcie actually put together, and it summarizes again the testimony that we heard about confidentiality.

And what we just wanted to do is to have Hope Cooper walk through this, not in great detail but enough to refresh our memories about what we've heard, and then we really want to look at where we take this. It doesn't go anywhere right now other than perhaps Commissioner Petit and Commissioner Rodriguez's subcommittee. This doesn't really rest anywhere and so just to have some idea of where we want to take this.

HOPE COOPER: Let me just touch on this with broad strokes. So this is just kind of a high-level summary of some of what the Commission has already heard about. It was really Florida, your Florida meeting where confidentiality was kind of on the agenda and they were right here kind of the center of the top page, sort of lists some of the panelists or speakers that you heard from.

You might remember the panel that had the journalist from the Miami Herald and even the lawyer from the child welfare agency, a judge and a state legislature. So they really addressed confidentiality in their remarks and additionally you heard from Howard Davidson, the Director of the Center for Children in our association. He really is one of the national experts who has looked at this issue for decades as it relates to child welfare and child protection and he had a very detailed set of recommendations that he shared but also sort of unpatched the federal law with respect to confidentiality and information sharing.

So a lot of that is covered in this memo but let me just sort of try to capture some of the take away points. Confidentiality and information sharing in the federal statute is really...with respect to child abuse and neglect records it's really nested within several large programs. CAPTA is sort of the main primary program that addresses this very specifically with respect to fatalities in particular. We have the privacy act --

CHAIRMAN SANDERS: Ms. Cooper, just for a second...this goes back to something that Commissioner Ayoub said. Could at least the first time for some of these could you use the full title so that if somebody is listening that they know what it means?

HOPE COOPER: Absolutely.

So these confidential provisions appear in a number of federal laws. The Child Abuse Prevention and Treatment Act is probably the primary federal law that addresses this, especially with respect to fatalities. There's also the Privacy Act of 1974 and there's a federal law HIPAA, for short but that's the Health Information Privacy and Protection Act, Health Information and Privacy Accountability Act. We also have title IV-E and title IV-B of the Social Security Act Program and those are the primary federal programs that govern the way that state child welfare agencies administer payments to foster care providers and their administration of their Foster Care Program so there are confidentiality provisions within that section of the federal law. There are a number of Public Health Service Act programs. The Public Health Service Act is another section of federal law that oversees a wide range of programs that are really administered by health officials in the state.

So this is just one example of the number of federal laws that have confidentiality provisions that would in some cases apply and at the state level and state agency lawyers have really taken into account a whole array of confidentiality and information sharing provisions.

With respect to CAPTA, the Child Abuse Prevention and Treatment Act program, there is a clear statement in federal law around the need for state agencies to safeguard the confidentiality of child abuse and neglect records and information. So that is sort of an overarching principal that must be managed and there are state laws that sort of reinforce that.

At the same time, CAPTA has been amended over the years to both allow or permit some information sharing of these records and in some cases it mandates that some information must be shared in certain circumstances, specifically with respect to a fatality. So CAPTA has sort of this spectrum of maintaining confidentiality of records and allowing...sort of continuum of allowing certain sharing and disclosure of this information. There has been a lot of assessment of these issues by issue experts and through government reports. Know how well are the current policies working at the state and local level so we have tried to capture some of the recommendations around this and these are both by government reports such as the GAO but also issue experts and advocates.

There's a clear sort of feeling that there could be and there needs to be better guidance from the Department of Health and Human Services around this issue. The guidance from them so far has come out in different amounts and in different ways. The regulations with respect to confidentiality for child abuse and neglect records have not been updated since 1990. So in one way the regulations are very old and folks have pointed out how they are out of date given that the CAPTA program has been updated and reauthorized a number of times since that time. And, in fact, in 2010 when Congress reauthorized the CAPTA program most recently one of the reports from the Senate asked HHS to issue its guidance to update its regulations in that way. So they were really enforcing the need for regulations around these issues.

The Department of Health and Human Services does provide guidance and information to states through a Child Welfare Policy Manual. This is a very active format that the state

agencies and the federal agencies use to communicate about the policy implications of federal statute. And through that format HHS has answered questions and provided additional guidance.

In 2012, HHS through that Child Welfare Policy Manual stated specifically what states must at a minimum release in the case of a child fatality. So states do have that amount of information and guidance regarding what at a minimum they must share in the case of a child fatality.

Additional sort of relevant information out of HHS and this is very new. In August of this year, HHS issued a confidentiality tool kit. And this is part of a larger project going on at HHS. I think the name of that is the Interoperability Initiative, the HHS Interoperability Initiative and this is being driven by several things. Really, we're changing technology that's going around and technology in general. The implementation of health laws and the Health Information Exchange is in particular about driving a lot of new information sharing but also within Human Services the need to assist states and doing the coordination that they are already required to do through many, many programs.

So HHS has led this initiative and released a confidentiality tool kit in August or September of this year and it has an entire chapter around child welfare programs and sort of serves as kind of a tool kit for state agencies on the laws that are relevant. And I have a feeling Wade probably knows a lot about this issue.

COMMISSIONER HORN: Actually, I was going...I'm afraid your answer is going to be, "I already did that and distributed it to you." (laughing) I may have missed that email. Can you develop maybe a summary of the tool kit and send that to the Commission?

HOPE COOPER: Absolutely.

So we have a number of federal programs that address specifically confidentiality and public sharing of child abuse and neglect records. We also have laws that address the data sharing or information sharing of these records across and among systems and with other stakeholders. We have different sort of mechanisms for guidance to states on how to do this. We have this initiative at HHS going on and we have a number of recommendations from the field around how to make improvements in this area.

The recommendations just to bring up a few that Howard Davidson raised when he spoke to you all in Florida. Talk about some new issues that haven't really been addressed so far at all in guidance, which is data sharing across state lines, for instance, and data around the near fatality cases. And public disclosure to the Commissioner around near fatality cases. And an assessment of state laws such as those that already address the unity protections. Some of those are stronger than others or clearer than others.

So there's a whole wide range of recommendations on this sort of issue topic.

In terms of next steps, I know the Commission has...or there has been some discussion around making this a focus of one of the upcoming meetings. Perhaps in January. There are a number of other experts that could talk to the complexity of this and sort of address what's going on currently in the field. Sort of what's the state of information sharing in child welfare and specifically around the disclosure of information around child fatalities. There is a report

every couple of years by the Children's Advocacy Institute for Star that gives states grades that ranks them on their state policies regarding the CAPTA requirements around disclosing information related to child fatalities. And we expect another report from them maybe next year, but I think they have a statement that they will be issuing possibly in December.

So if someone from that organization would have a lot of information to share with the Commission... there's a lawyer who has done a very detailed analysis of all the 50 state laws on confidentiality and compliance with those state laws and the federal CAPTA requirements, so there's quite a bit of analysis out there that could be very informative to the Commission.

CHAIRMAN SANDERS: Thank you. And I wanted to also ask if Tom Morton could maybe speak to this issue. Specific to work that we had asked him to do in looking at previous reports from state commissions that were similar to this to see if this issue of confidentiality or sharing of information has come up in recommendations from state commissions.

COMMISSIONER RUBIN: One of the other questions. I know it was raised in Philly and it was also raised in yesterday's testimony, something for you guys to think about.

When we talked about this issue in Philadelphia, particularly around sharing health information on kids in the child welfare system the differentiation was made between are you talking about sharing the child's information or the parent's information. And we had a comment yesterday made about participation in Opiate, in the substance abuse programs. And this is not an opinion about whether we should be sharing or not sharing parent's information but I think that you might want to differentiate the two on how it's handled by the law so you can inform our discussion.

TOM MORTON: Commissioners, basically what I was asked to do was to identify and collect various kinds of reports that had been produced by Commissions, auditors or other entities that had reviewed child welfare systems, either following a crisis of general nature in performance or a fatality. I actually reviewed eight reports that are varied in terms of their source. Two of them Chairman Sanders participated on, one in Philadelphia and one in Los Angeles County. Another report was done by the Colorado Child Abuse Review Team, the internal review team. For example, another was an audit of an agency done by the state auditor in California.

I would say in regard to recommendations targeting the agency oversight accountability and transparency out of 200 recommendations contained in these eight reports, only one specifically addressed fatalities; and that was to hold an annual public hearing on child fatalities, including a focus discussion on infantile or deaths.

The other recommendations are around oversight accountability and transparency and were largely much broader in terms of the agency reporting about its outcomes. Such as, and in some cases, strengthening mechanisms. For example, the other recommendations in this area were to ensure that child fatality review panel has resources and staffing to provide multidisciplinary recommendations, strength and internal capacity to review fatalities, the board should adopt clear outcome measures, the board should continue its active oversight over the agency. The board should require regular reporting on the frequency of missed monthly social worker visits, wait time for children in offices, et cetera. The agency should assume greater accountability for its performance. To develop an annual report card. Develop comprehensive strategy and you get the flavor of that.

But the point is, I don't want to say these eight reports are representative. They are a convenient sample, very small one. But it was interesting to me in assembling this report that actually a few of the recommendations addressed specific risk factors for child abuse and neglect fatalities. And with recommendations on how to directly affect or influence those risk factors. But in regard to transparency, there was really only one recommendation and that was to hold an annual meeting.

CHAIRMAN SANDERS: So we wanted to open this up really to look at where we want to go with this issue.

COMMISSIONER BEVAN: Thank you

CHAIRMAN SANDERS: Thanks, Tom.

Commissioner Petit, I know you need to leave. Is there anything that you'd like to say to start this out?

COMMISSIONER PETIT: I'm hoping that we can have the same kind of discussion devoted to this topic as we have with a couple of others recently, which I think would be very useful to just bat it all around in terms of...I think everyone agrees, I think everyone agrees there needs to be modifications in confidentiality law but what there is an agreement on is yet or what are the options on that? So whether it's a teleconference call in November or December but I think we need to be on it and I think it's an issue that will attract a lot of attention because the press is interested in this issue. So I'm hoping that...

CHAIRMAN SANDERS: While you're in the cab.

COMMISSIONER PETIT: What's that?

CHAIRMAN SANDERS: We'll probably continue part of this discussion while you're in the cab.

COMMISSIONER PETIT: Well, Jennifer and Tom will alert me to what's going on.

Is Bud Kramer on the phone? No, okay, sorry.

CHAIRMAN SANDERS: Commissioner Horn.

COMMISSIONER PETIT: I'll see you later. I'm out of here.

(laughing)

COMMISSIONER HORN: I started bringing this issue up yesterday and I think that as we go to the next round of conversations about this...I do think this is a critical issue around data sharing is particularly given the fact that so much information is now being collected and maintained in an electronic fashion. There are really three issues that you have to worry about. Confidentiality is one. Security is another and the third is privacy.

Security we probably can all understand you have to make sure that the information is secure for someone who is not authorized can't get to it. Confidentiality is about the degree to which

you are empowered or able to share information and what information must be kept confidential. But the piece that I think that we have been missing so far in the conversations really is the expectation of privacy.

So I would hope that we have some discussion of that when we reconvene or whatever forum that is to talk about it, expand it from just confidentiality to really about...cause it's really not about confidentiality so much as about sharing information and then confidentiality and privacy or two issues I think are important in that regard.

CHAIRMAN SANDERS: Commissioner Ayoub.

COMMISSIONER AYOUB: Recently in Las Vegas there was a sex trafficking case and it was horrific. Definitely a near-death situation and it was reported in detail in the press. And the victim has told some people that she was embarrassed by that. They want her to come back and testify and to be there. Now, there's really a lot of details about her injuries that were embarrassing to her and the whole situation was embarrassing besides painful. So I'd like to hear about confidentiality or privacy from that perspective and from the child's perspective.

And Commissioner Rodriguez, I don't know if you are comfortable sharing something or that you had that perspective of what that...while we're talking about it. It's great to share information. What does it mean on the privacy side to somebody that's in that situation?

COMMISSIONER RODRIGUEZ: I think there's two issues. There's the issue about sharing externally, sort of with the media. I think that's really touchy. Generally speaking, I think journalists try to be ethical about it but some of them are not, especially when there's been a near fatality or a fatality and there's siblings remaining and their family's information is all over the newspaper and often times the abuse that occurred to the sibling who died also has occurred to them and we're in an age now where you can be 40 and somebody can Google you and that case from when you were 6 comes up for everybody. So I think that's one issue is keeping information that we use for this purpose external.

But then the other issue, I think, is around...there has to be real caution about sharing information between agencies for the purpose of "helping" but then there's also always the danger that that information gets shared inappropriately with folks and it ends up stigmatizing the years or particularly when it comes to public health information and health information having everybody have access to sort of what your diagnosis was and the abuse that happened to you is often really difficult and frankly my experience has been that, confidentiality gets used while you're in foster care in like every single way to prevent you from everything that you want to do under the sun, for the child and then everybody else violates confidentiality all the time when it's convenient for them.

So I think there's a number of issues, but I think some of the biggest ones are making sure that that information is private in terms of not getting leaked outside and digging -- I mean, it's alarming what Commissioner Covington said earlier that the information gets released publicly on some of the death reviews with the names and all of the details, because I'm not sure what the purpose of that is. I don't know why the public needs to know the child's name and identifying information in order to understand the story.

COMMISSIONER AYOUB: In the Las Vegas case the article was about today, the child death from foster care, every name was released.

CHAIRMAN SANDERS: Commissioner Martin.

COMMISSIONER MARTIN: So I have a strong, strong affinity for what you just said. I oftentimes try very hard even when legally it's available and permissible in order to help another child, a sibling, this whole issue of anticipatory neglect, it is very difficult for me to make those decisions because I always will get the sib and they're right -- to release what they want to release about their family and their background. But I also do -- I mean, I'm one jurisdiction that still closes my courtroom. It's closed with an anticipatory opening based on my order only. So I really do feel very strongly about confidentiality.

Having said that, however, there is some value in releasing some information but it does not have to be Sally Sue, five years old, attending Franklin School on Joseph William Street. So I think that it's not just releasing information, it's what we release and for what purposes and restricting it to just that purpose. And so I would ask us to be very mindful of that because these other children, even if remove them out of their home when it's appropriate to do so, they still have a life to live. And so I think that it is very important that we make certain that when we talk about releasing and sharing information it's for specific purposes, it's for a limited time.

So it's not like if I'm seeing a psychiatrist, it's not...you release all my psychiatric reports, it's for a limited purpose, for a limited time maybe and restrict the names and ages of the children. Because I do think that's a very important factor that we have to consider.

COMMISSIONER RODRIGUEZ: And for siblings who survive, I think often times justice for them is the ability to be able to move on with their life and not --

COMMISSIONER MARTIN: Not be identified as a family member.

COMMISSIONER RODRIGUEZ: Well, not to be identified as a family member and not to have everybody have access to all of the horrific things that happened in their earlier years. I mean, it really is...I've worked with youth after youth who have had issues about being in the military and trying to get weapons clearance and then having somebody be able to pull up sensitive information that should have been protected in their child welfare file and being denied that clearance or being denied law enforcement, being able to get into law enforcement or into a government job because child welfare information, particularly mental health information but also people are unbelievably nosy in a disgusting way.

So they want every sordid detail of the things that happened to you beyond what it takes to, and so I mean, just the idea of that you are going to have people who grow up, they become parents, they're going to become community members and they don't want everybody knowing their early childhood story. They want a chance to be able to keep that information private. Like we all do. I think that's probably true for everyone one, you want your private life to remain private unless you want it disclosed.

CHAIRMAN SANDERS: Commissioner Bevan.

COMMISSIONER BEVAN: I totally agree with what you're saying. My issue here is not using any names but when a child dies, I want to know, I want to make sure that an agency, CPS, is not

hiding it's wrongdoing behind the issue of confidentiality. I mean, that is something that we don't know...talk about not getting transparency, a child is dead, and there needs to be information to get system improvement and also of course I seem to be the only one who's interested in prosecuting and tracking people down. (laughing)

COMMISSIONER MARTIN: That's not true.

COMMISSIONER BEVAN: I don't want this to be on the record. On the record that Judge Martin shook her head in agreement with me. (laughing)

COMMISSIONER MARTIN: I do agree with you. I do agree.

CHAIRMAN SANDERS: Commissioner Horn.

COMMISSIONER HORN: So sometimes the things that I miss are the things that should be obvious, and you said something that should have been obvious to me and it wasn't. I'm so old I grew up in the days when everything was in paper files and if you wanted to find an old newspaper article you had to go the library and get these things called microfiche and go through it with a little machine like this, and it took you forever, and today you Google your name and everything comes up. And I think that that...we need to think about this issue in that context because it's not going to go away. You don't have to go to the library anymore. It is an instantaneous thing that you can do to bring up people, people's history. And I know there are a lot of issues about this. I think in the E.U. they just had some ruling about the "Right to be forgotten" or something like that, which is not a law and there's not a ruling that governs the United States.

So I think we have to be even more careful in today's world that we don't inadvertently harm more people because of the release of information which in some levels seem reasonable to do and the other it seems to me we have to have a compelling reason to put that out there knowing that it's not going to be erased anytime soon and probably will stay with you for the rest of your life. So I really appreciate your...it didn't hit me until you said that and I really appreciate the comment.

COMMISSIONER RODRIGUEZ: We work very careful about protecting child welfare workers' identities. I mean, that's...when you read the stories you notice there's always...and then you realize there's protections and there's reasons and there may be cases pending but you will almost never see the name or any identifying information of the anonymous investigators or child welfare workers who falsified records unless litigation happens at some point. But for children, there's identifying information that gets disclosed left and right.

CHAIRMAN SANDERS: If I could make just a couple of points. I think one is to the question that Commissioner Ayoub asked in the beginning, and I know that Commissioner Rodriguez knows quite a bit about this.

In Los Angeles, the Chief Judge did move to change the presumption to a presumption of openness in the court and did that as a District Court Judge. It was ultimately overturned but the opposition to that was brought by you. That they were concerned about information being shared by them, which I think led to...I think it was the Appeals Court that looked at it and overturned it.

COMMISSIONER RODRIGUEZ: That is correct. I mean, young people felt adamantly that they did not want...in Los Angeles we had a Juvenile Court Judge who felt that it was very important to have public accountability and wanted to open up Juvenile Court hearings to ensure that the public would be able to come in and hear all of the agencies failings and sort of hold the system accountable, but young people felt very, very strongly that this was...the information that gets dealt with in court hearings is the most sensitive information possible. You're talking about sexual abuse. You're talking about neglect. You're talking about the progress of parents who frequently you still love a lot and care about and so you don't want it sensationalized and frequently what reporters are interested in is not small details they are interested in sort of the worst possible details about your life. So it made you very uncomfortable. So they actually organized pretty effectively in the state to really protect confidentiality, which I think was interesting to a lot of people in other countries who had been framing the issue of Open Courtrooms as an issue to sort of protect young people.

CHAIRMAN SANDERS: Let me just mention the second piece and then I know a couple of you have comments.

I many years ago was part of a system that went from a presumption of the system being closed, courts being closed, to courts being opened and it was one of the few that made kind of a visible transition from a closed system to an open system, and that was in Minnesota; and it was actually done through the Commission, similar to this, the Supreme Court Foster Care Commission. Obviously, it was controversial that switch was then evaluated for, I believe it was two years, to look at a variety of factors which have long exited my memory. But the gist of the final evaluation that it didn't have any impact one way or the other. There didn't appear to be any real change in coverage. The frequency of coverage. The type of coverage didn't seem to create anything negative. I mean, basically after the initial couple of days the media responded in almost exactly the same way as they had before.

So I don't know how many of those experiments have been out there where there's at least some qualitative information about the impact. That would be something that we want to take a look at.

CHAIRMAN SANDERS: Commissioner Martin, then Commissioner Rubin.

COMMISSIONER MARTIN: So the National Council of Juvenile and Family Court Judges have been involved in this issue for quite some time. In fact, I have been one of the persons that has briefed this and argued this. I lost in the National Council. So the National Council's policy is that the court should be presumptively open and should close upon specific order of the presiding judge. I am one of the few courts in the nation, particularly one of the larger courts in the nation, that still remains closed. And to get to come into my court you have to come up to my office and get an order specifically from me to go into my courtroom.

But what I've done, though, is I've tried to then cure, if you will, to the best possible way I can when I do let the media in. So I typically always let the media in. Don't let them know that. No, I always let the media in. But I have them come inside and order with me as well. That contract is that they cannot take pictures of my kids families, they cannot list identifying information, so you can't say Sally Sue, five years old that lives on West 19th Street or whatever. If, in fact, they feel it's imperative to put identifying information in their story, prior to them printing they have to call me and we have to discuss it.

Yes, it's really local but it's worked well.

I also offer siblings petitions, the willingness to hear their petition to change their last name. I've done that for quite a few sibling groups who have changed their last name. And it gets tricky in some jurisdictions 'cause you also remember, I'm a closed jurisdiction for adoption. So if I adopt sibling A, the other siblings are basically divorced if they are not adopted in that same sibling group. So this issue goes far beyond just what happens in a courtroom and a media person or a reporter writing about one story.

So I think there are ways in which we can kind of try to protect a child by offering petitions to change names and stuff like that but we can also work with the media on specific contracts and local communities. And that doesn't mean that they are always going to agree and it does rely heavily on the rapport you have with the media. But I am also the kind of person that takes time to bring the media in when there is not a major issue going on to just talk about how the system runs. So they know they get access to me and I hope that helps me in terms of protecting my kids and families identity.

I do think there are ways in which to work on it, but it is a very important issue and nothing ever happens to the workers. Workers don't get fired. Rarely do workers get fired. If they do, they just go to the next agency down the street; and I still have seen the same workers in my courtroom.

So if we're talking about confidentiality for accountability of the people who have done something wrong, again, that's not the way to do it. Not the way we're doing it.

COMMISSIONER HORN: Directors and Commissioners do get fired. Sometimes in my view, inappropriately.

COMMISSIONER MARTIN: Yeah, 'cause I get mad when I see the same worker.

CHAIRMAN SANDERS: Commissioner Rubin.

COMMISSIONER RUBIN: I actually like the fact, Commissioner Horn, that you brought up that you differentiate confidentiality privacy 'cause I couldn't agree with you guys more about the privacy issues and how violating it feels when we read some of those stories of the kids out there in that way. Confidentiality side, for me the ambiguity across the different laws, whether it's HIPPA or whether it's on the medical side or other confidentiality laws, I feel like that ambiguity even though it's written into different laws all that ambiguity has created a situation where there's a lack of transparency about which requests are going to be approved, because people can hide behind that ambiguity and justify whether they think this is a good idea or a bad idea. So even if it currently exists in different places, I feel like there's...particularly when a child dies or a near fatal injury and how that information is used, aside from the privacy issues, which I agree are extremely important, really trying to get above the noise and make very clear expectations of permissible activities where everyone should agree.

I'll give you an example. In Philadelphia we were...we have been trying for a couple of years now to acquire behavioral health data on kids for more of a public health concern that kids were being overprescribed antipsychotics and multiple cocktails and meds and you can imagine a child welfare system might be able to examine the residential facilities and find out

which facilities were principally doing this. That has not been an easy conversation to navigate what something is about safety. And potentially, there are kids who are committing suicide at these facilities.

So I think that I would encourage us to really think about trying to rise above the noise and I don't want to recreate the process, a lot of you are just looking at these confidentiality issues but for the activities we're talking about near fatal injuries and fatalities and the urgency around them and somehow trying to come out with some consensus statements around it.

CHAIRMAN SANDERS: I should point out one last thing. In Minnesota when the switch occurred to the presumption of openness the opportunity existed for counties to voluntarily participate in the test of this idea, it required the agreement of the Chief Prosecutor, the Chief Judge and the Child Welfare Director, and I was the Child Welfare Director at the time. I did -- I was actually a strong supporter, and one of the reasons that I was, and I think it's part of the discussion, was the fact that in the county at that time, 20 to 30 percent of the Child Protection cases were also prosecuted and they were open. Those cases that were prosecuted were open and oftentimes law enforcement had shared information about the children, about the acts of the parents and so forth. So it was difficult to distinguish that 30 percent from the other 70 percent.

So that was one of the -- for me, it was one of the compelling arguments that much of this information is open right now in those states where there is more frequent prosecution.

COMMISSIONER RODRIGUEZ: This makes me think to that it's -- I know this is not a policy issue but that it's a lot about the relationships that exist between people and so, I mean, right now where we have people who are sort of doing their own thing and they are not doing it together in terms of investigations, if we change that and people actually did feel like a team across agencies I actually think there would be a lot less skepticism about sharing information.

And I recently, just a few months ago, was visiting in a county in California where they have a team that has put together a multidisciplinary team to deal with young women who are trafficked. And you have prosecutors and public defenders sharing information for the purposes of developing a case plan for the young women that will help them heal, which is sort of unthinkable, absolutely unthinkable, but because they've been in this structure with law enforcement behavioral health, child welfare, the Public Defender and the prosecutor and it is actually the prosecutor that convenes. There is now enough trust across lines that people actually are willing to share information because they have a common goal and that goal is to help the young women heal and to get them safe.

So it just makes me think that if we move to a system where we actually did have multidisciplinary investigations and sort of support for families that some of these things would be resolved naturally if we could get to rise above the noise. If we could get clarification on the law and that the information can be shared for a limited and specific purposes that protect children and families privacy, then I think some of the noise will disappear if people were actually were working together and had reason to use it in the course of their work.

I know this doesn't really help us with the recommendations but I think some of it happens in practice.

COMMISSIONER HORN: I think that's really helpful, actually, and I want to first of all associate my remarks with Dr. Rubin's remarks about, at least let's put clarity into what can and cannot be shared. It just doesn't make a whole lot of sense, as Howard Davidson discussed and presented to us, that HHS hasn't updated the regulations on confidentially information sharing despite the fact that there have been fairly dramatic changes in the law, and instead, have done it mostly through a policy manual. And I think that I would certainly put on the table that one of our recommendations should be that HHS should rationalize current law with its regulations in order to provide the kind of clarity so that they can't hide it because of lack of clarity.

Now having said that, I also want to say I agree with you that there are...we also don't want to get so tied into can't share anything that when it makes sense to share information for the benefit of the child that that information get shared. So if Commissioner Petit were here, I'm sure he would tell us the stories of the guy who gets released from prison and is beating up half the world and nobody tells the family that the guy has been released from prison. You know, there ought to be some reasonable ways for us to share information to protect children. In addition to providing multidisciplinary treatment plan to intervene, and that's in some way a different issue for me than releasing information to the general public that then is just out there, I haven't thought through all of that yet so I'm not prepared yet to say we shouldn't release anything to the general public, but I think that there are different levels...what you're able to share to protect a child, what you're able to share to intervene and provide appropriate interventions and what you share to the general public are three different things.

COMMISSIONER RODRIGUEZ: I agree. And in the internal information sharing, I think sometimes it's as simple as a policy clarification.

But we recently had California state legal department clarify was that we were having county after county refuse to share any information with foster parents about the biological family and so which, obviously, creates a lot of challenges for a family who is trying to care for a child and they have no idea what the safety risks are about the family. They have no idea -- a simple thing as this child was abused in the bathtub and they've got to give that child a bath and they have no reason...they have no sort of context for understanding why the child is completely traumatized every time they bring him by water.

So we had our state legal department clarify that. In fact, the department is authorized to share anything with caregivers that's not prohibited by law, which they were looking at it the opposite way, which is that the department was not authorized to share anything with caregivers unless they were specifically authorized to do so in law. So just that simple clarification has helped immensely and they were just very clear: Here are HIPAA prohibitions, here are sort of what is existing -- I know, I see a look on your face. I know some of county council has come back challenging some of the legal interpretation which will always happen but I think it was really helpful just to have that policy statement. It didn't even involve a legal change but just that they were clear: Here's the reason why you should share information, it's because caregivers are an important part of the team and that we want them to work with families and as such share everything except for these things.

So it seems to me that on the internal part if we said "You are allowed to share everything with each other as agencies for the purposes of intervening with the family, treating a family,

keeping a child safe except where there is a specific prohibition," that alone that kind of a small thing might be helpful.

COMMISSIONER HORN: That's kind of the way the law is written. And that's the thing that people don't get. It's not like we have to rewrite that law.

COMMISSIONER RODRIGUEZ: Exactly

COMMISSIONER HORN: That's the law as currently written.

COMMISSIONER MARTIN: I agree with the -- I see you guys are all looking at me like I disagree. (laughing) No I agree fully with what you're saying. (laughing)

CHAIRMAN SANDERS: So for this issue it seems like we don't have...well, what we need is to have a place that this can be further examined and brought back to the full Commission. It seems that it rests in the kids known to the system subcommittee but we could look at other places to.

COMMISSIONER RUBIN: The only other thing I would add is...I'm wondering if this is really even relevant because maybe this is more of a child welfare service delivery, but one of the things -- there was some progress on FERPA in terms of school records that a child in foster care where we could begin to share school records, and I think while a lot of advocates celebrated that, I think about the 95 percent of the kids who are not -- who have active child protective services caseloads and you'd like to kind of help those kids too and why that artificial distinction, I think, in a lot of the confidentiality and stuff it often -- for the kids in foster care you can do this but everyone it's kind of -- it's left very ambiguous and I think we have to think about the child welfare system as a kid whose got an active case and try to have some level of standardization. If you can. I think there are tradeoffs there and I would like to understand those tradeoffs 'cause certainly there are folks that have thought about that but it's kind of an artificial distinction for a child in the child welfare system who may be transitioning in and out of foster care.

COMMISSIONER MARTIN: I think it's also helpful what Commissioner Horn said about maybe leveling this out, thinking about it on different levels. Like, what recommendations, if we have any, to share information with the public and how we might do that and what restrictions we might put on it.

So I think that was really helpful when you said that, for me at least. Because I can think of clearly distinctions -- I mean, I get requests all the time from criminal defense lawyers to release child protection records for either the defense or the prosecution of a criminal case. So I think there are ways in which we can look at this on a tripod or a tri-level mechanism.

CHAIRMAN SANDERS: So Jennifer, you're representing the subcommittee. (inaudible)

COMMISSIONER RODRIGUEZ: (inaudible) I don't think we have enough work so sure, might as well. I would encourage anybody who would like to join our subcommittee to do so.

(laughing)

COMMISSIONER RUBIN: I think Commissioner Petit would volunteer.

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(laughing)

CHAIRMAN SANDERS: Is there anything else that we need to discuss today? If not, I will call this meeting adjourned. Thank you.

MEETING ADJOURNED